CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries

Provider Portal User Guide

For Eligibility and Provider users

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1 Purpose

This User Guide is for Eligibility and Provider users of the Provider Portal web application, a secure web based application, to access information provided by Care Improvement Plus.

This guide provides a detailed overview of the application's functionality, based on a menu driven sequence as displayed in the Home Page, as well as an intuitive dashboard interface for all sections on the landing page for a more visual experience. It also provides a step-by-step process on how to use the application and all of its features effectively.

2 Accessing the Portal

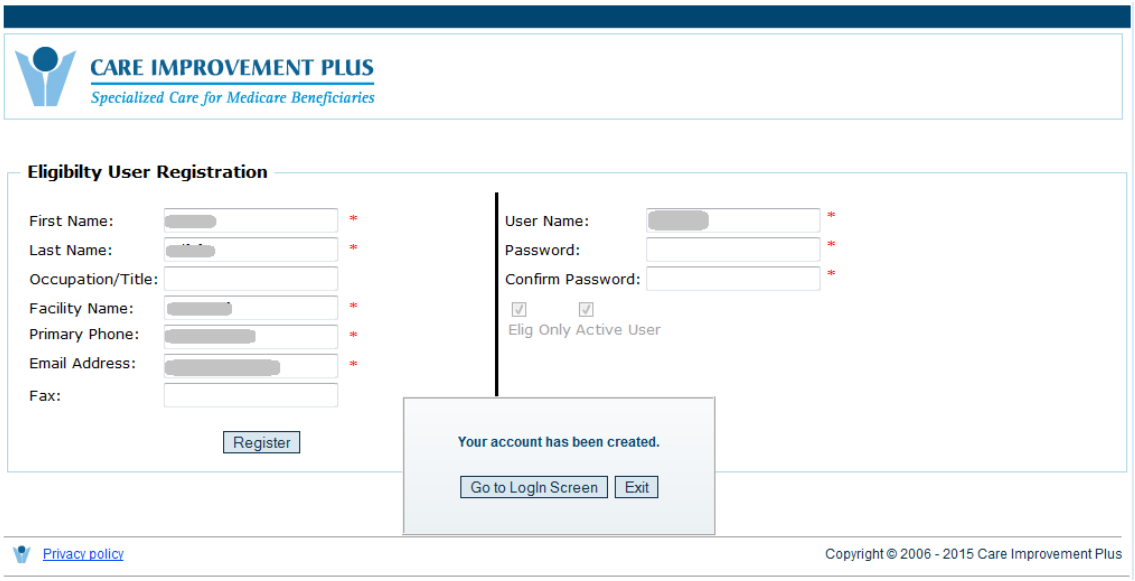
2.1 Login

1. To access the Provider Portal click on the link below: https://providerportal.careimprovementplus.com/ . This log-in box will appear:

CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries
Login Information
Please enter your username and password.
Username:
Enter username here
Password:
Enter password here
Log In
Forgot/Reset Password
Welcome to the Care Improvement Plus Provider Portal.
Whether you are a Participating or Non-Participating Provider, you can access the Provider Portal.
If you want to register as a new user please click
Self Register
View Self-Registration tutorial

2. Key in your Username and Password.
3. If you forgot your password, click “Forgot Password?” and enter your Username and email address on file then click “Reset Password”. Your password reset link will be emailed to you on the email address we have on file.
4. If the User does not have an account, the user can click the “Self Register” button.
5. If the User clicks the Self Register button, the user will need to select one of the two options listed.
    a. To view Member Eligibly only (Eligibility user):
        - Select radio button “I agree to use the Provider Portal to view Eligibility Only” > Click “I Agree”
        - Fill in all user Registration Information (red asterisk indicates information that is required” >

- Please note that the password must contain at least one digit, one upper case, one lower case, one special character, range between 8-15 characters and should not be a user name.
- Once you enter the entire user registration information click on 'Register', you will be prompted to go to the login screen.



b. To view Claim Information (Provider user):
   - Select radio button "I agree to use the Provider Portal to view Claim Information" > Click "I Agree"
   - You will need to call Provider Portal Support: **1-800-690-1916** to set up the account.
   - You will also be able to view the Eligibility Information.

6. Once you are able to logon, the user will arrive on the Home Page.

Tutorial Videos: The user can also access the Self-Registration *Tutorials* through the Log In page.

CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries
Login Information
Please enter your username and password.
Username:
Enter username here
Password:
Enter password here
Log In
Forgot/Reset Password
Welcome to the Care Improvement Plus Provider Portal.
Whether you are a Participating or Non-Participating Provider, you can access the Provider Portal.
If you want to register as a new user please click
Self Register
View Self-Registration tutorial

3 Eligibility User Experience

3.1 Home

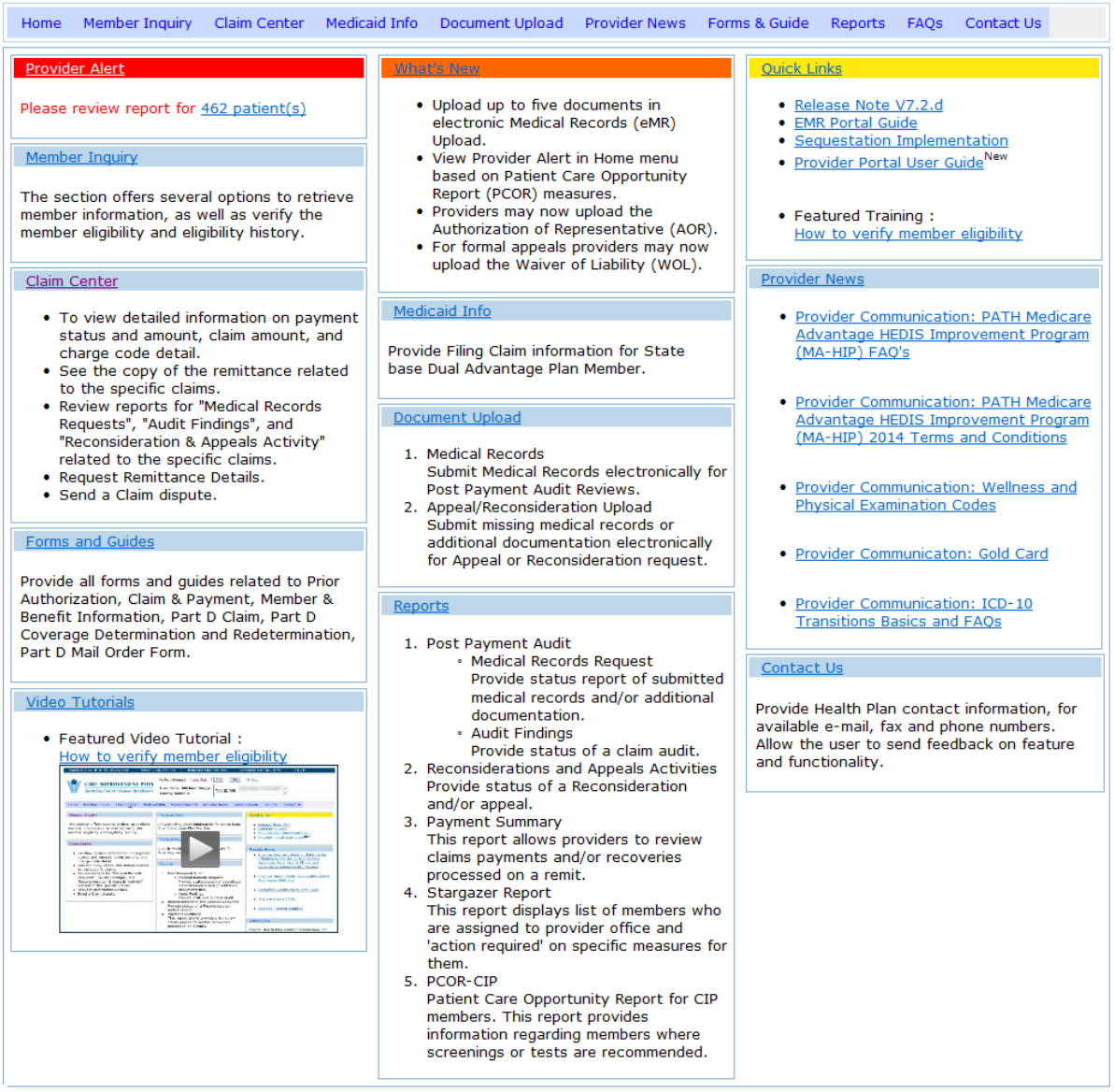
As an **Eligibility user**, the user will have limited access to the portal. The following menu will be available to the user:

- Home
- Member Inquiry
- Medicaid Info
- Provider News
- Forms and Guides
- FAQ's
- Contact Us

Home
Member Inquiry
Medicaid Info
Provider News
Forms & Guide
FAQs
Contact Us
Member Inquiry
The section offers several options to retrieve member information, as well as verify the member eligibility and eligibility history.
Video Tutorials
Featured Video Tutorial :
How to request a remit if one is not immediately available
Forms and Guides
Provide all forms and guides related to Prior Authorization, Claim & Payment, Member & Benefit Information, Part D Claim, Part D Coverage Determination and Redetermination, Part D Mail Order Form.
Quick Links
Release Note V7.1
EMR Portal Guide
Sequestation Implementation
Provider Portal User Guide New
Featured Training :
How to request a remit if one is not immediately available
Provider News
Provider Communication: Inpatient Part A Provider Fact Sheet
Provider Communication: Wellness and Physical Examination Codes
Provider Communication: Inpatient Rehabilitation Facility Documentation Guidelines
Provider Communication: Electronic Prescribing Bonus Incentive Payment
Provider Communication: KX Modifier Therapy Services
Contact Us
Provide Health Plan contact information, for available e-mail, fax and phone numbers. Allow the user to send feedback on feature and functionality.

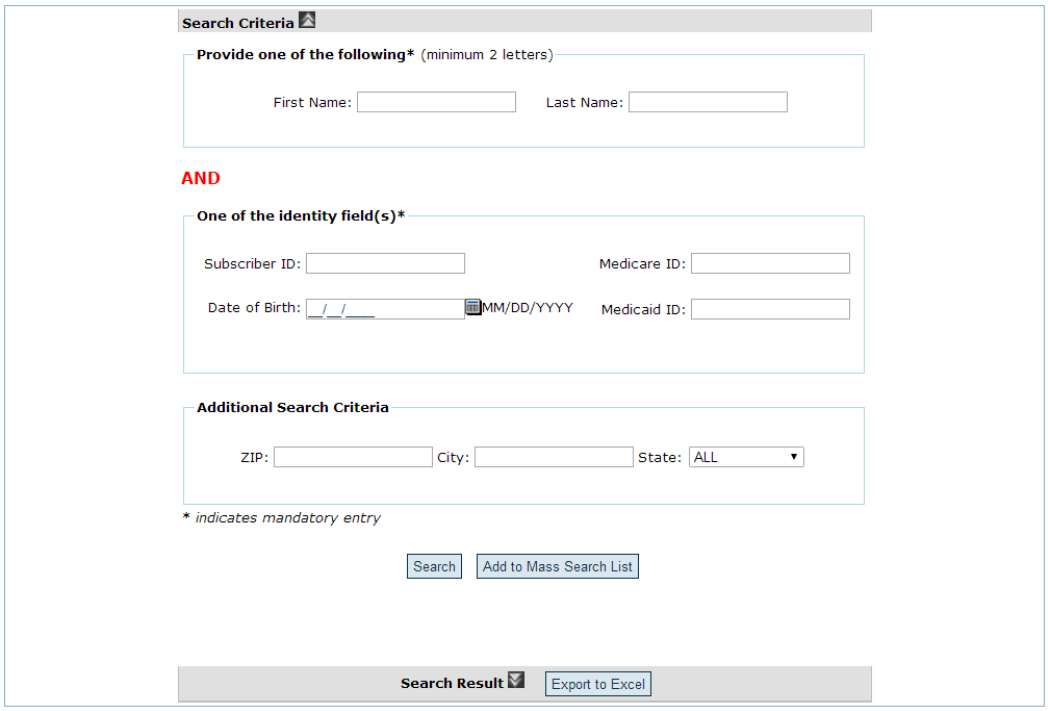
As a **Provider user**, the user will have access to more features (in addition to the features Eligibility users are able to access):

- Claim Center
- Document Upload
- Reports


Home
Member Inquiry
Claim Center
Medicaid Info
Document Upload
Provider News
Forms & Guide
Reports
FAQs
Contact Us
Provider Alert
Please review report for 462 patient(s)
Member Inquiry
The section offers several options to retrieve member information, as well as verify the member eligibility and eligibility history.
Claim Center
To view detailed information on payment status and amount, claim amount, and charge code detail.
See the copy of the remittance related to the specific claims.
Review reports for "Medical Records Requests", "Audit Findings", and "Reconsideration & Appeals Activity" related to the specific claims.
Request Remittance Details.
Send a Claim dispute.
Forms and Guides
Provide all forms and guides related to Prior Authorization, Claim & Payment, Member & Benefit Information, Part D Claim, Part D Coverage Determination and Redetermination, Part D Mail Order Form.
Video Tutorials
Featured Video Tutorial :
How to verify member eligibility
What's New
Upload up to five documents in electronic Medical Records (eMR) Upload.
View Provider Alert in Home menu based on Patient Care Opportunity Report (PCOR) measures.
Providers may now upload the Authorization of Representative (AOR).
For formal appeals providers may now upload the Waiver of Liability (WOL).
Medicaid Info
Provide Filing Claim information for State base Dual Advantage Plan Member.
Document Upload
1. Medical Records
Submit Medical Records electronically for Post Payment Audit Reviews.
2. Appeal/Reconsideration Upload
Submit missing medical records or additional documentation electronically for Appeal or Reconsideration request.
Reports
1. Post Payment Audit
Medical Records Request
Provide status report of submitted medical records and/or additional documentation.
Audit Findings
Provide status of a claim audit.
2. Reconsiderations and Appeals Activities
Provide status of a Reconsideration and/or appeal.
3. Payment Summary
This report allows providers to review claims payments and/or recoveries processed on a remit.
4. Stargazer Report
This report displays list of members who are assigned to provider office and 'action required' on specific measures for them.
5. PCOR-CIP
Patient Care Opportunity Report for CIP members. This report provides information regarding members where screenings or tests are recommended.
Quick Links
Release Note V7.2.d
EMR Portal Guide
Sequestation Implementation
Provider Portal User Guide New
Featured Training :
How to verify member eligibility
Provider News
Provider Communication: PATH Medicare Advantage HEDIS Improvement Program (MA-HIP) FAQ's
Provider Communication: PATH Medicare Advantage HEDIS Improvement Program (MA-HIP) 2014 Terms and Conditions
Provider Communication: Wellness and Physical Examination Codes
Provider Communicaton: Gold Card
Provider Communication: ICD-10 Transitions Basics and FAQs
Contact Us
Provide Health Plan contact information, for available e-mail, fax and phone numbers. Allow the user to send feedback on feature and functionality.

3.2 Member Inquiry

This section offers several options to retrieve member information, as well as verify the member eligibility and eligibility history. When you click the “Member Inquiry” menu, you will get the following search screen:



- Under *Search Parameters* you can enter any combination of the following
  - Member’s First Name or Last name (Minimum 2 letters)

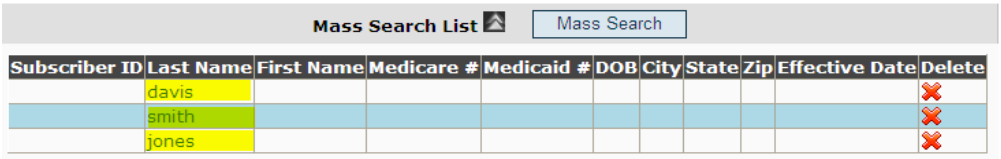
    AND

    Any one of the following
  - Subscriber ID;
  - Medicare Number;
  - Medicaid #;
  - Date of Birth.

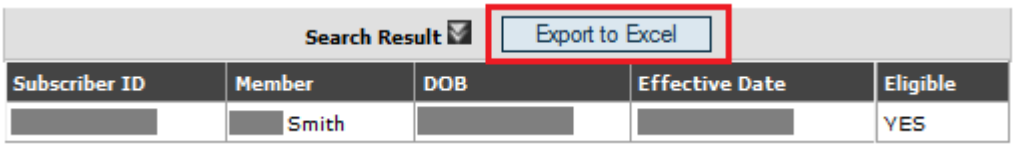
Enter the member information as per search parameters and click on *Search* and it will list the results associated with the search request.

You also have the option of narrowing down the search by adding any additional information in the *Additional Search Criteria* box, though this is not required.

- If you want to do **multiple searches** at one time, you can enter the same combination above and click on *Add to Mass Search List*. Once you have added all of the members that you were looking for into the *Mass Search List* you can then click on *Search* and it will pull all results for those names.

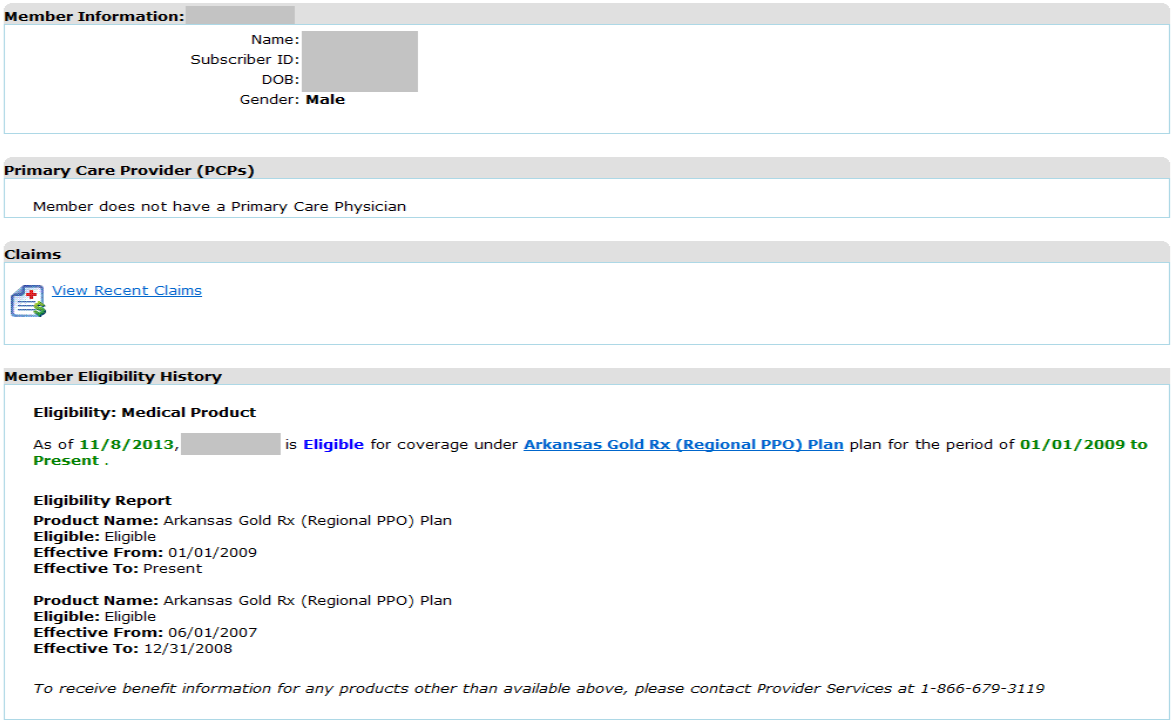


- Another feature under the Member Inquiry is *Export to Excel*. This button allows you to save and print an excel spreadsheet of members you received in your Search Results.



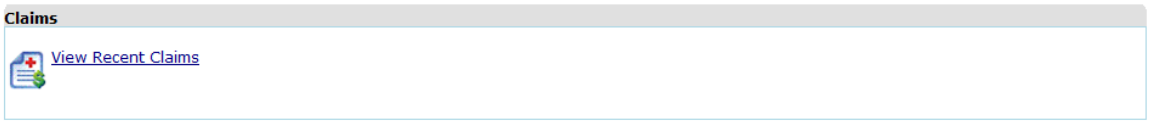
- After you have located your Member, click on the Subscriber ID link to access the details of their record in the *Member Details* screen.

Member Details - Displays basic Member Information, such as, member name, subscriber ID, Date of Birth and Gender, Member's PCP as per Health Plan records, Eligibility History and Member Plan details.


Member Information:
Name:
Subscriber ID:
DOB:
Gender: Male
Primary Care Provider (PCPs)
Member does not have a Primary Care Physician
Claims
View Recent Claims
Member Eligibility History
Eligibility: Medical Product
As of 11/8/2013, is Eligible for coverage under Arkansas Gold Rx (Regional PPO) Plan plan for the period of 01/01/2009 to Present .
Eligibility Report
Product Name: Arkansas Gold Rx (Regional PPO) Plan
Eligible: Eligible
Effective From: 01/01/2009
Effective To: Present
Product Name: Arkansas Gold Rx (Regional PPO) Plan
Eligible: Eligible
Effective From: 06/01/2007
Effective To: 12/31/2008
To receive benefit information for any products other than available above, please contact Provider Services at 1-866-679-3119

Primary Care Provider (PCPs) – Displays the member's Primary Care Physician as per Care Improvement Records.

- **Claims** – displays a link to the Claim Center search page. If the user is an Eligibility user, the user will see a message *"Currently your User account is for viewing Eligibility. If you would like to add Claims permission please call Web Portal Support 1-800-690-1916"*
- If the user has a Provider role that links to a specific Provider's Tax ID or NPI listed in their User Account, the user will see the View Recent Claims icon. By clicking on this icon, the user will be able to view the most recent claims submitted by that member.



- The user may view the summary of a member's healthcare benefits plan by clicking the coverage plan information link found in the Member Eligibility History section.

Member Eligibility History
Eligibility: Medical Product
As of 11/8/2013, is Eligible for coverage under Arkansas Gold Rx (Regional PPO) Plan plan for the period of 01/01/2009 to Present .

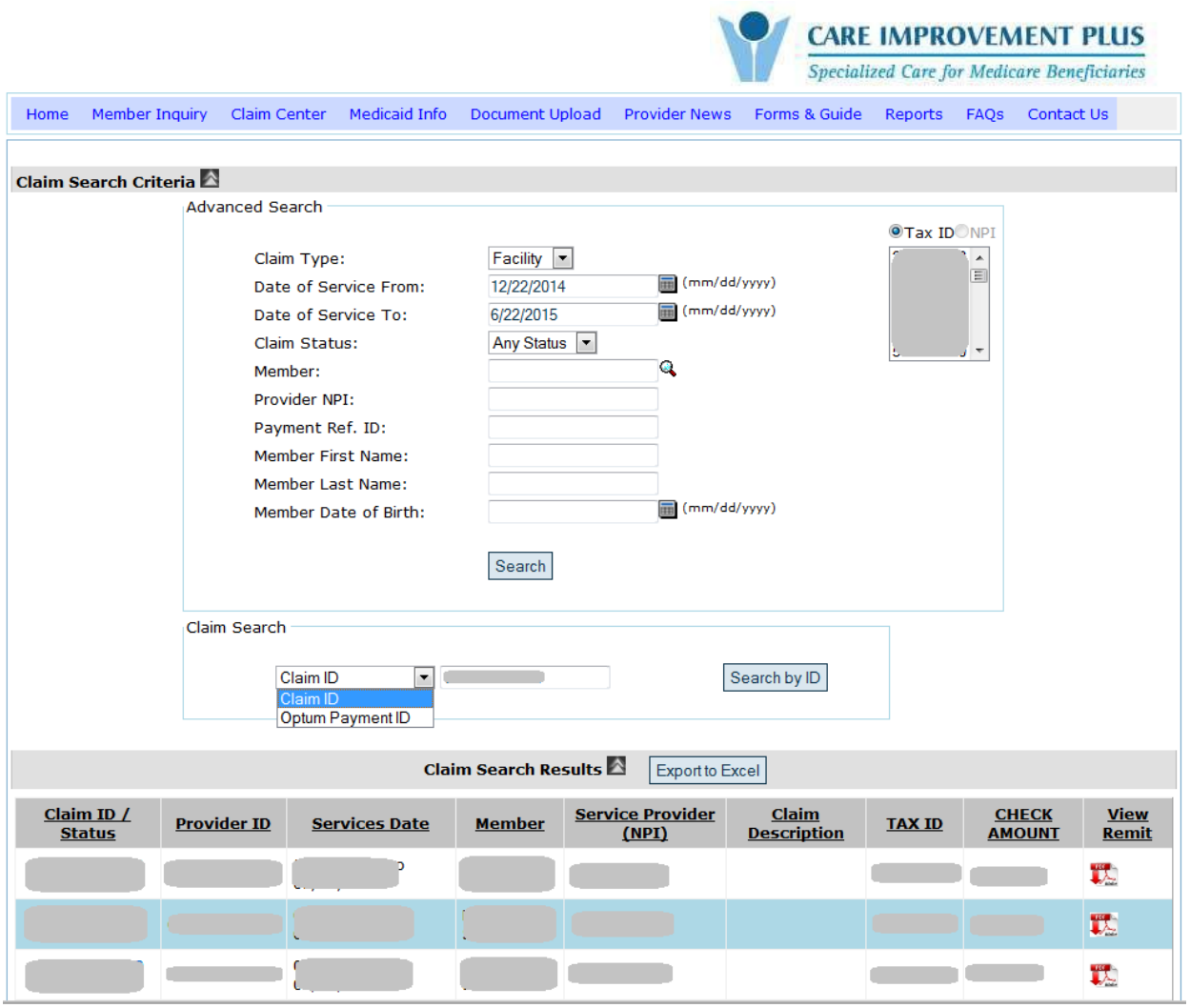
3.3 Claims Center

This page is accessible by any user that has provider role access to the application. Eligibility users will not be able to have the option. The Claim Center page is useful:

- To view detailed information on payment status and amount, claim amount, and charge code detail.
- To see the copy of the Remit related to the specific claims.
- To review reports for Post Payment Audit Report, such as "Reconsideration & Appeals Activity", "Medical Records Requests", and "Audit Findings" related to the specific claims.
- To request Remittance Details.
- To send a Claim dispute.

There are two ways to reach to the Claim Center page: On the Member Detail Page, click on the *View Recent Claims* icon or from the main menu by clicking the Claim Center tab. On this page:

- You will see a Search Criteria Box.
- You will have the option to search by **claim type** - Facility or Medical.
- You may enter in **dates of service date range** (this defaults back to a 6 month span) or use the calendar to pick dates.
- By clicking on the drop down box next to the **Status** field you can choose from a list of options -- ***Processing, Processed and Adjusted Claims***.
- The **Members First and Last Name** will be carried over from the Member Details screen if you access this page from the Member Details page. Otherwise, you can click the search icon to find the member first.



- After you have made your selection, click the Search button. A list of **Search results** should display at the bottom of the screen. By clicking on the column headers, you may sort the information in ascending or descending order.
- If you have Claim ID or Optum Payment ID available, you may select the appropriate search type, enter the Claim ID or Payment ID number and click on “Search by ID” button to view the claim details for entered information as shown in above figure.

- The user can hide the *Claim Search Criteria* or *Claim Search Results* by clicking on the adjacent icon.

- Click the icon in the **View Remit** column of the search results to view Remittance (EOP) in PDF form of the concerned claim, if one is available. For more information on Remits, see section 3.3.1 (Claim Details page).

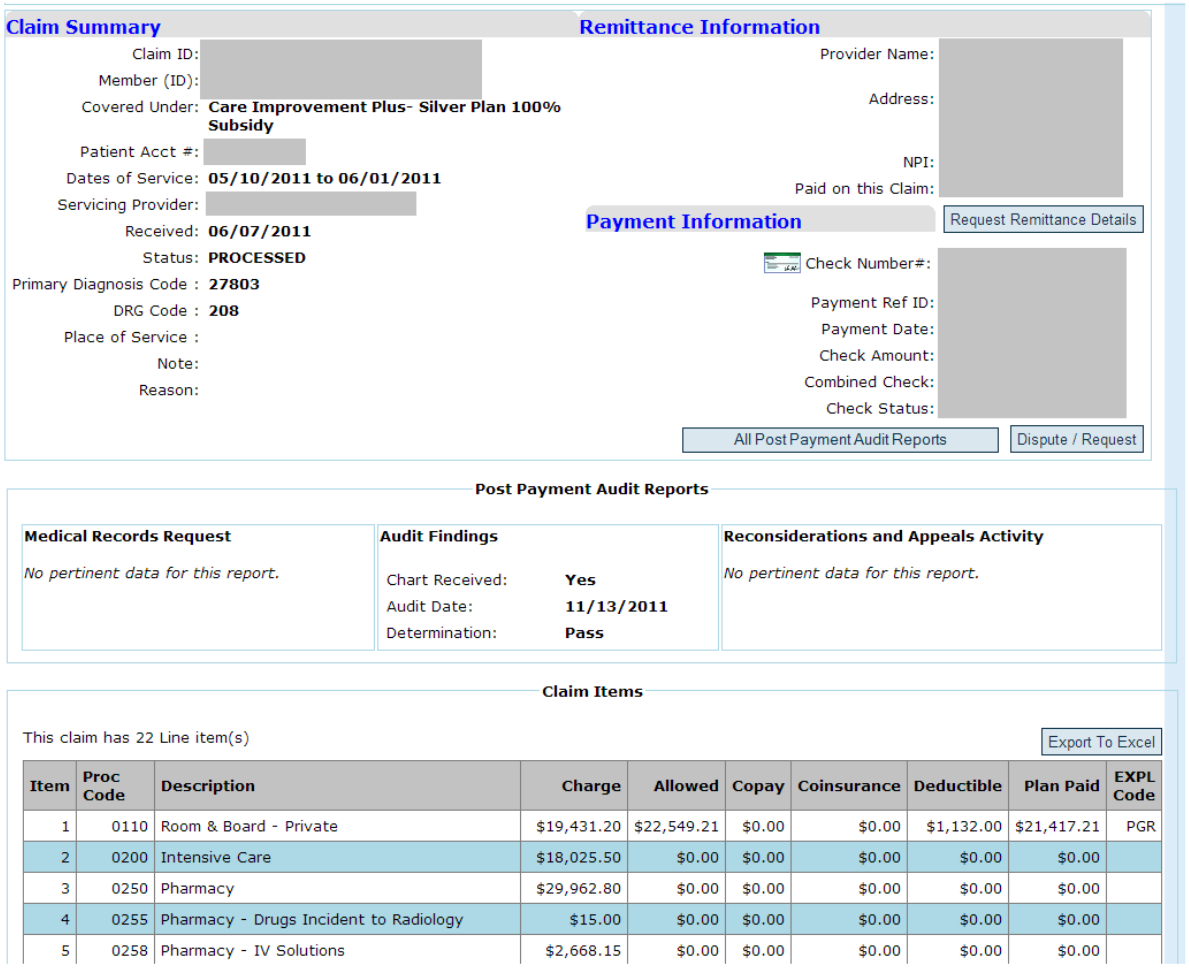
If the Members Claim does not match to the NPI or Tax ID associated with this User Account and click Search, No Records should appear with “No Results found” message

- Under the Claim search results you will see an **Export to Excel** button. This will allow the option to save the Search Results into excel spreadsheet.

- By clicking on each Claim ID number, it will take you to a screen where you can view claim details which are generated from the database.

All Member information will be protected unless the User has access to view the Claims information by NPI or Tax ID

3.3.1 Claims Details page



Claim Summary

Claim ID:
Member (ID):
Covered Under: **Care Improvement Plus- Silver Plan 100% Subsidy**
Patient Acct #:
Dates of Service: **05/10/2011 to 06/01/2011**
Servicing Provider:
Received: **06/07/2011**
Status: **PROCESSED**
Primary Diagnosis Code : **27803**
DRG Code : **208**
Place of Service :
Note:
Reason:

Remittance Information

Provider Name:
Address:
NPI:
Paid on this Claim:

Payment Information

Request Remittance Details

Check Number#:
Payment Ref ID:
Payment Date:
Check Amount:
Combined Check:
Check Status:

All Post Payment Audit Reports | Dispute / Request

Post Payment Audit Reports

Medical Records Request	Audit Findings	Reconsiderations and Appeals Activity
No pertinent data for this report.	Chart Received: **Yes** Audit Date: **11/13/2011** Determination: **Pass**	*No pertinent data for this report.*

Claim Items

This claim has 22 Line item(s) — Export To Excel

Item	Proc Code	Description	Charge	Allowed	Copay	Coinsurance	Deductible	Plan Paid	EXPL Code
1	0110	Room & Board - Private	$19,431.20	$22,549.21	$0.00	$0.00	$1,132.00	$21,417.21	PGR
2	0200	Intensive Care	$18,025.50	$0.00	$0.00	$0.00	$0.00	$0.00	
3	0250	Pharmacy	$29,962.80	$0.00	$0.00	$0.00	$0.00	$0.00	
4	0255	Pharmacy - Drugs Incident to Radiology	$15.00	$0.00	$0.00	$0.00	$0.00	$0.00	
5	0258	Pharmacy - IV Solutions	$2,668.15	$0.00	$0.00	$0.00	$0.00	$0.00	

On the Claim Details page, you will see six sections:

- Claim Summary
- Remittance Information
- Payment Information
- Payment summary
- Post Payment Audit Reports
- Claim Items
- Claims bundled into same check (If any)

On claim summary page, you can find the claim and associated details to it such as claim id, Member ID, Patient account Number (If any), Coverage Type, Dates of service, Servicing Provider, Claim received date, Claim Status, Primary Diagnosis Code (If any), Place of Service, Reason and Note for the given claim if any.

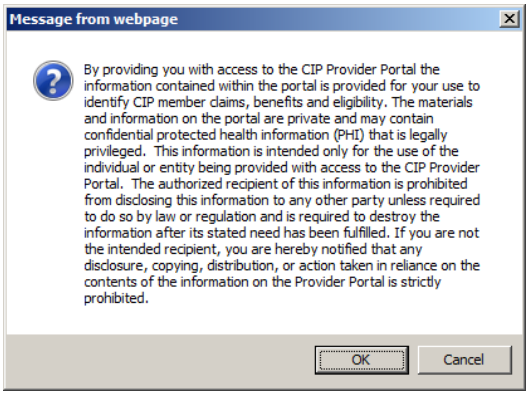
Beside this information on claim detail page, hovering the cursor on '***Servicing Provider Name***' will show the servicing provider address, while hovering the cursor on ***EXPL Code*** of Claim Items will show explanation/Note for that selected code.

There are four additional buttons available on this page.

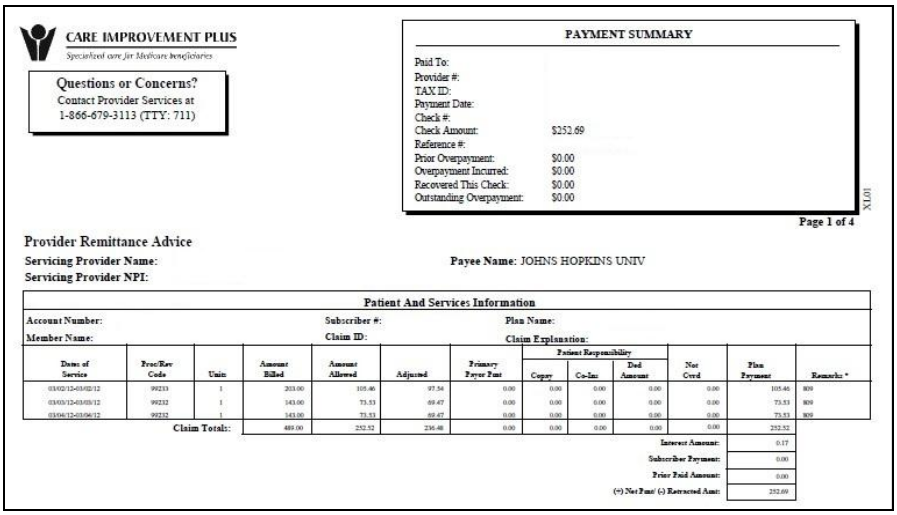
- Request Remittance Details
- Dispute
- All Post Payment Audit Reports
- Export to Excel (To export claim line items and Bundled claims details)

Post Payment Audit Reports will display any relevant data for the claim. If there is no audit report data available, it will state 'no pertinent data for this report' as shown in the figure above.

Clicking the **Request Remittance Details** button will display an image of the Remit if the claim payment is **after July 1, 2009**. Prior to showing the available Remit file, a confidentiality disclaimer message will be displayed (see below).


Message from webpage
By providing you with access to the CIP Provider Portal the information contained within the portal is provided for your use to identify CIP member claims, benefits and eligibility. The materials and information on the portal are private and may contain confidential protected health information (PHI) that is legally privileged. This information is intended only for the use of the individual or entity being provided with access to the CIP Provider Portal. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of the information on the Provider Portal is strictly prohibited.
OK
Cancel

Clicking OK will then display the PDF as shown below:



CARE IMPROVEMENT PLUS
Specialized care for Medicare beneficiaries

Questions or Concerns?
Contact Provider Services at
1-866-679-3113 (TTY: 711)

PAYMENT SUMMARY

Paid To:	
Provider #:	
TAX ID:	
Payment Date:	
Check #:	
Check Amount:	$252.69
Reference #:	
Prior Overpayment:	$0.00
Overpayment Incurred:	$0.00
Recovered This Check:	$0.00
Outstanding Overpayment:	$0.00

XL01

Page 1 of 4

Provider Remittance Advice

Servicing Provider Name:
Servicing Provider NPI:

Payee Name: JOHNS HOPKINS UNIV

Patient And Services Information

Account Number: **Subscriber #:** **Plan Name:**
Member Name: **Claim ID:** **Claim Explanation:**

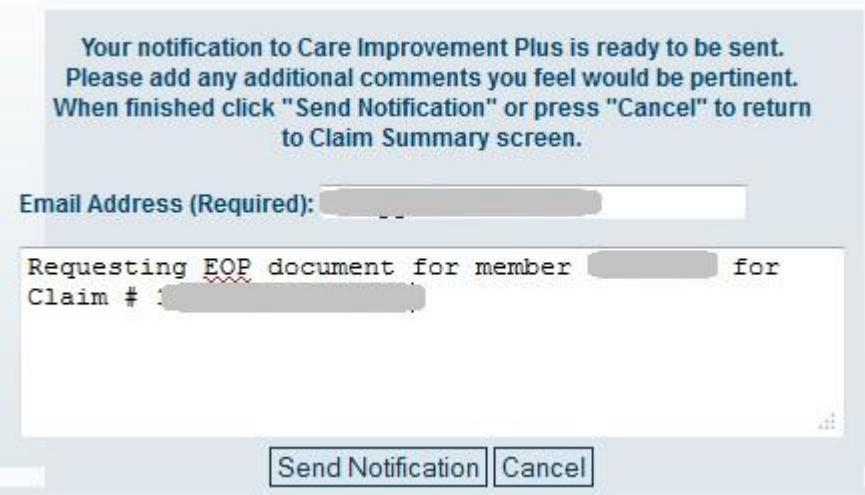
Date of Service	Proc/Rev Code	Units	Amount Billed	Amount Allowed	Adjusted	Primary Payer Paid	Patient Responsibility: Copay	Co-Ins	Ded Amount	Not Cvrd	Plan Payment	Remarks *
03/02/12-03/02/12	99233	1	203.00	105.46	97.54	0.00	0.00	0.00	0.00	0.00	105.46	M9
03/03/12-03/03/12	99232	1	143.00	73.53	69.47	0.00	0.00	0.00	0.00	0.00	73.53	M9
03/06/12-03/06/12	99232	1	143.00	73.53	69.47	0.00	0.00	0.00	0.00	0.00	73.53	M9
	Claim Totals:		489.00	252.52	236.48	0.00	0.00	0.00	0.00	0.00	252.52	
											Interest Amount:	0.17
											Subscriber Payment:	0.00
											Prior Paid Amount:	0.00
											(+) Net Paid/ (-) Retracted Amt:	252.69

Keep in mind that the processing for this claim may still be taking place, and that it might take longer for this to be completed due to the timing of the submission (i.e. prior to a holiday, week-end, etc.). Usually a good rule-of-thumb is to wait around 6-7 days after the claim was first submitted to ensure its availability.

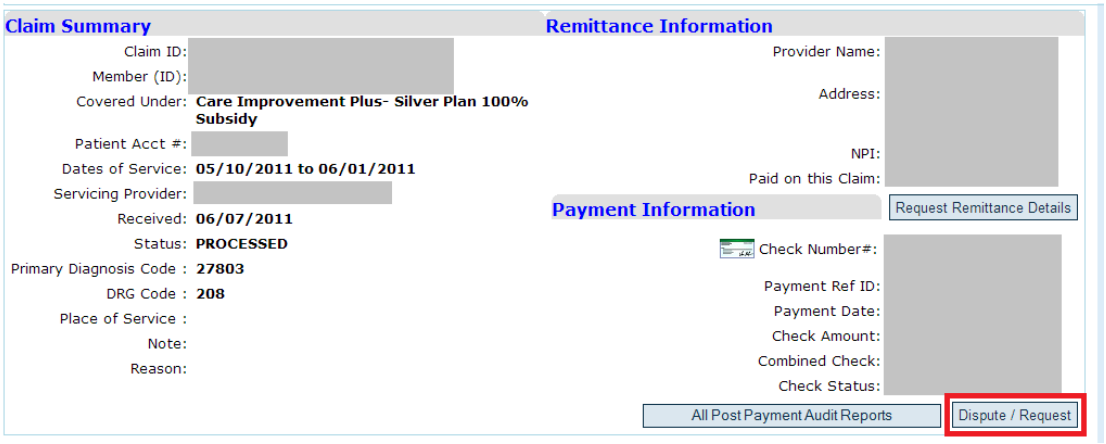
If the claim payment is processed prior to July 1, 2009, the user will automatically be directed to **the Request Remittance Window** as shown below, where the user can enter a valid email address and/or fax number to have the Remit image is sent.

The Remittance Information for this payment is not available via this website.
Please click "Request Image" button to request image or press "Cancel" to return to Claim Summary screen.
If you prefer to receive image via fax, please provide an email address and a fax number.
Email Address (Required):
Fax (Optional):
Request Image
Cancel

Clicking the **Request Image** button will then open the notification window, where the user may add any comments or notes regarding this claim request. Fill in all necessary information, and then click the **Send Notification** button to send the request to Provider Portal support team. A message will appear stating that ***your request was sent successfully*** and a response will be sent to you within 1-3 business days.


Your notification to Care Improvement Plus is ready to be sent.
Please add any additional comments you feel would be pertinent.
When finished click "Send Notification" or press "Cancel" to return to Claim Summary screen.
Email Address (Required):
Requesting EOP document for member for
Claim #
Send Notification
Cancel

Click the **Dispute/Request** button on the Claim Detail page to request an explanation about the claim. A dispute window will prompt the user to answer **OK** or **Cancel**



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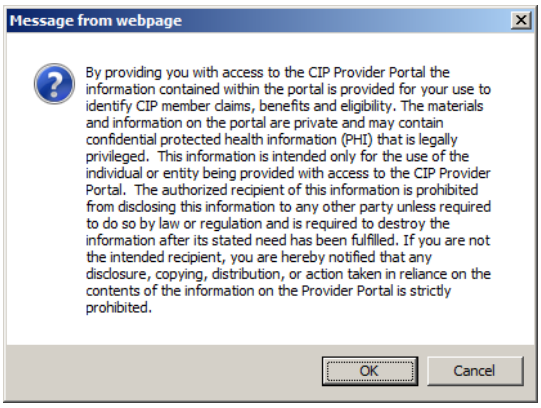
Message from webpage
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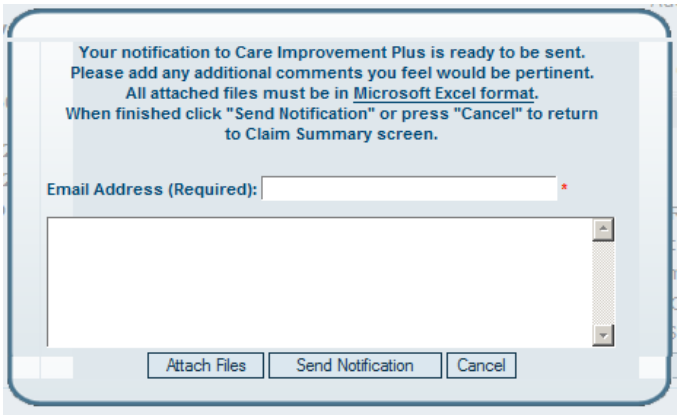
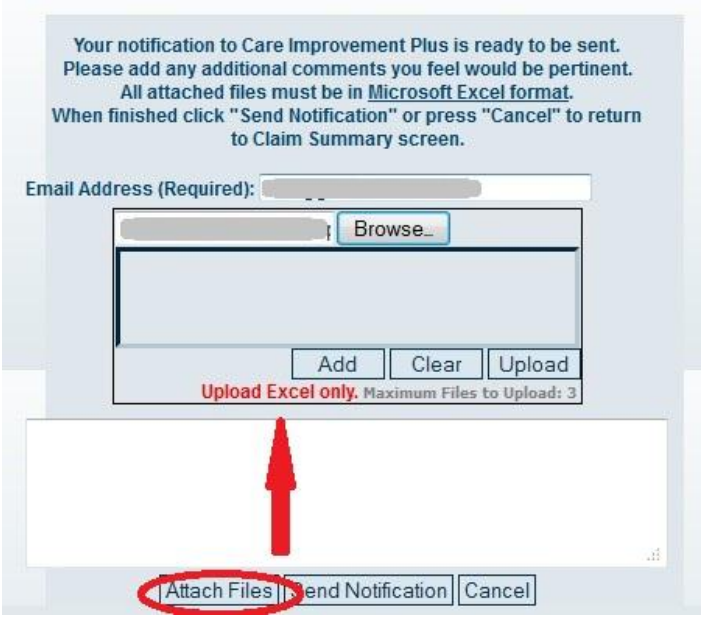
OK
Cancel

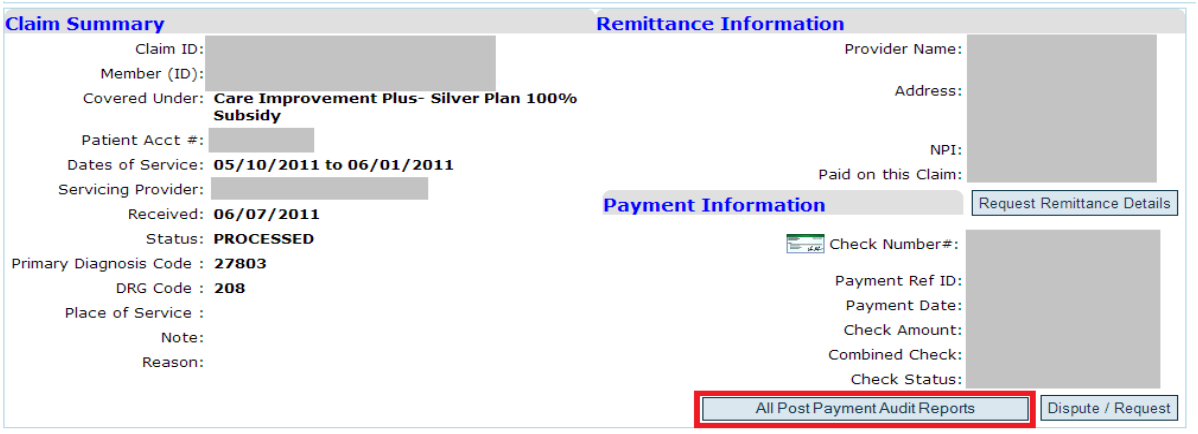
Clicking *OK* will bring the user to the next step to enter the e-mail address, add a message and attach Excel-only files which are related to the claim.


Your notification to Care Improvement Plus is ready to be sent.
Please add any additional comments you feel would be pertinent.
All attached files must be in Microsoft Excel format.
When finished click "Send Notification" or press "Cancel" to return to Claim Summary screen.
Email Address (Required):
*
Attach Files
Send Notification
Cancel


Your notification to Care Improvement Plus is ready to be sent.
Please add any additional comments you feel would be pertinent.
All attached files must be in Microsoft Excel format.
When finished click "Send Notification" or press "Cancel" to return to Claim Summary screen.
Email Address (Required):
Browse...
Add
Clear
Upload
Upload Excel only. Maximum Files to Upload: 3
Attach Files
Send Notification
Cancel

- When attaching file(s), click the **Browse** button to search for a local Excel file to upload, then once selected click **Open** in the file selection window. The path to that file should now be listed in the field next to Browse. Click **Add** to add it to the queue of Excel documents to be uploaded. Once you've selected up to three documents that you wish to include, click **Upload** to send them to the database. Once the **Send Notification** button is clicked, the IT staff and vendor will receive an email with this information, including links to all the Excel documents that were attached.

You will be redirected to Post Payment Audit Reports by clicking the "All Post Payment Audit Reports" button



3.4 Medicaid Info

This page provides claims filing information for Care Improvement Dual Advantage Plan Members in the following eligible states: **Arkansas, Georgia, Missouri, South Carolina, Texas and Wisconsin**.

3.5 Document Upload

This section allows the provider users to submit/upload the medical records, Appeal (Redetermination)/Reconsideration (Technical Denial) upload. Click on the *Document Upload* menu and go to the appropriate module to upload the intended documents.

Home
Member Inquiry
Claim Center
Medicaid Info
Document Upload
Provider News
Forms & Guide
Reports
FAQs
Contact Us
Admin
Document Upload
Medical Record Upload
Appeal/Reconsideration Request Upload
Care Improvement Plus requests medical records according to the guidelines set forth by CMS for fee-for-service Medicare. The Plan provides 30 calendar days for providers to fulfill each medical record request.
Providers may file a formal Appeal following an adverse determination with Care Improvement Plus. If a denial was issued due to missing/insufficient medical records, a Reconsideration request may be submitted; providers may supply missing medical records or additional documentation for consideration by the Plan.
Click here to upload a Medical Record by using Document ID
Click here to upload a Medical Record by using Claim ID
Click here to upload an Appeal/Reconsideration Request

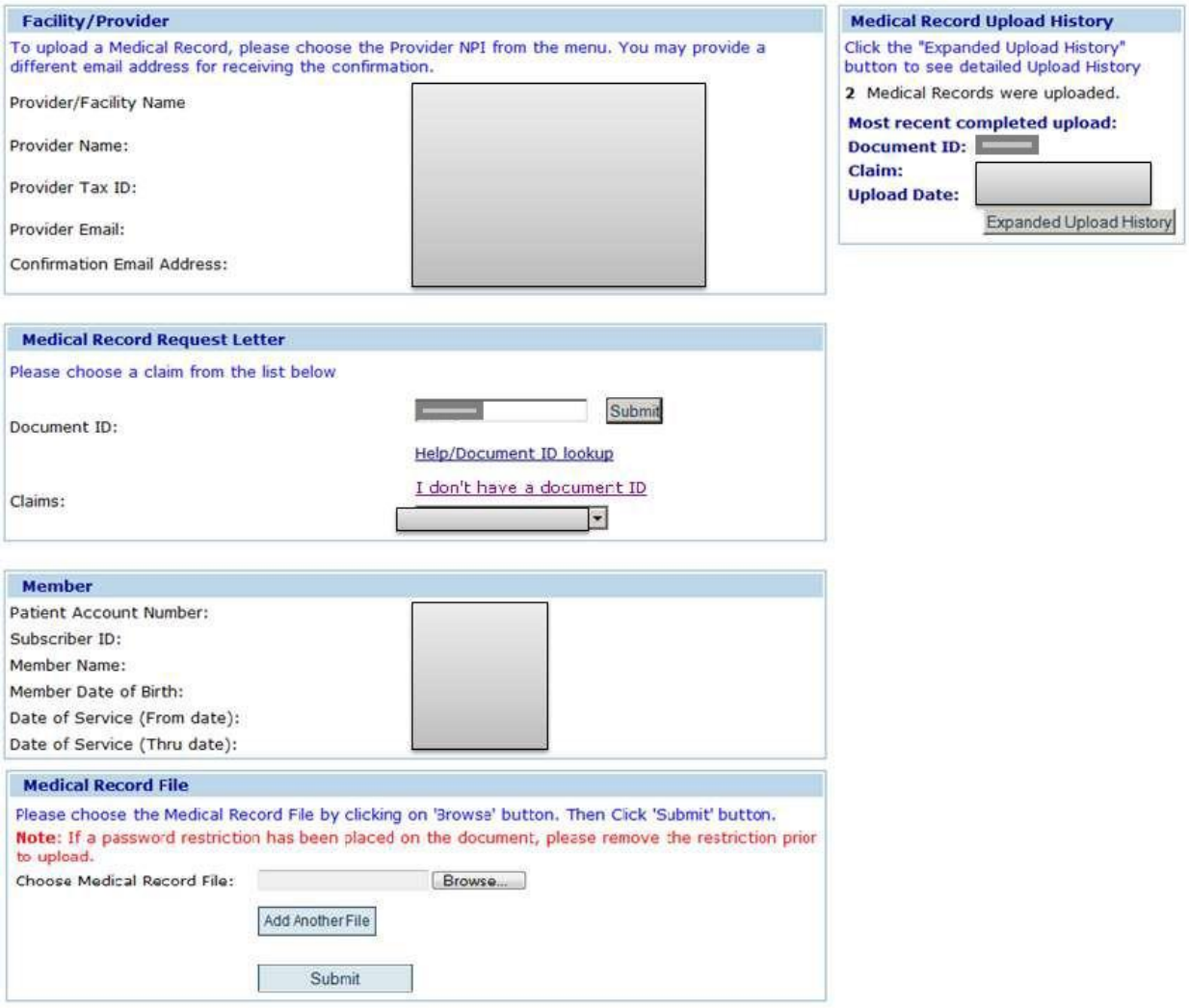
3.5.1. Medical Record Upload

The Medical Records upload module allows the user to submit/upload electronic health records requested by Care Improvement Plus. It also allows the user to find the Medical Record Upload History by clicking on the *Expanded Upload History* button on the top right corner of the page.

To upload the Medical Record documents, click on “Medical Record Upload” or “Click here to upload a Medical Record by using Document ID” link if you have document ID (you may find this in Medical Record Request letter that you received) available for the claims you want to upload the documents. You may chose “Click here to upload a Medical Record by using Claim ID” if you do not know or do not have the Document ID available.

CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries
Home
Member Inquiry
Claim Center
Medicaid Info
Document Upload
Provider News
Forms & Guide
Reports
FAQs
Contact Us
Admin
Document Upload
Medical Record Upload
Appeal/Reconsideration Request Upload
Care Improvement Plus requests medical records according to the guidelines set forth by CMS for fee-for-service Medicare. The Plan provides 30 calendar days for providers to fulfill each medical record request.
Providers may file a formal Appeal following an adverse determination with Care Improvement Plus. If a denial was issued due to missing/insufficient medical records, a Reconsideration request may be submitted; providers may supply missing medical records or additional documentation for consideration by the Plan.
Click here to upload a Medical Record by using Document ID
Click here to upload a Medical Record by using Claim ID
Click here to upload an Appeal/Reconsideration Request

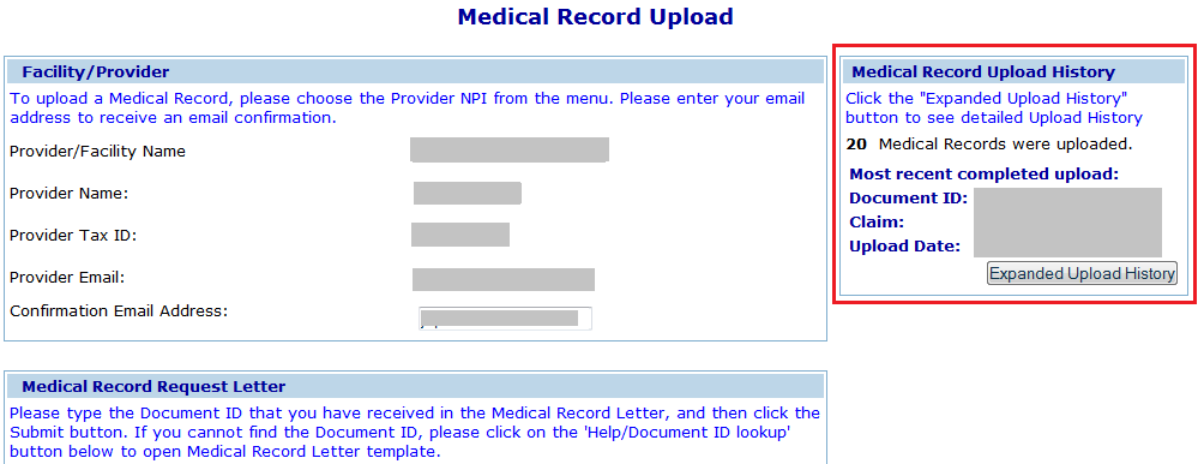
If user's account is associated with multiple Tax ID/NPIs then user should select the one from the Provider Tax ID/NPI drop downs menu.

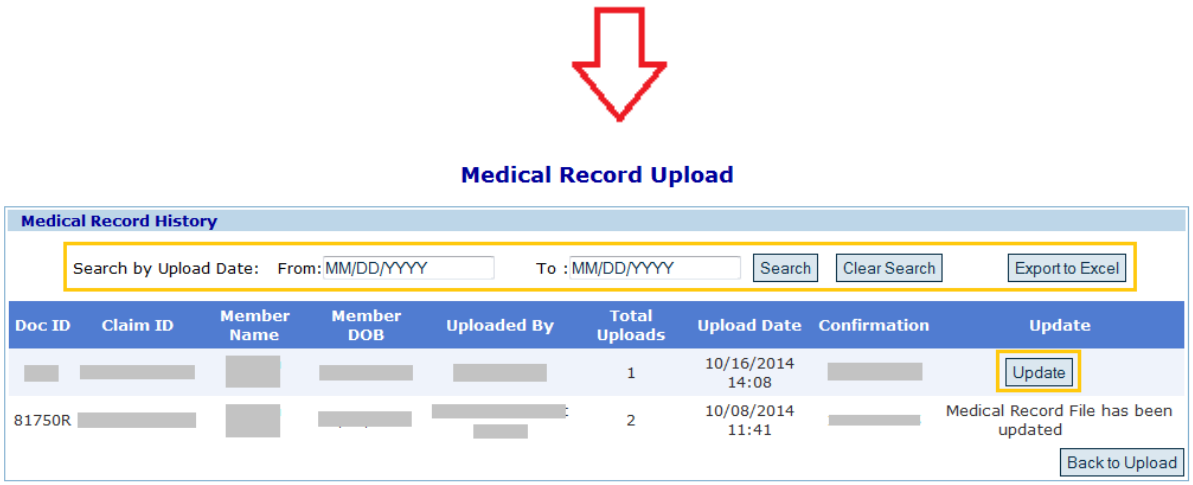

Facility/Provider
To upload a Medical Record, please choose the Provider NPI from the menu. You may provide a different email address for receiving the confirmation.
Provider/Facility Name
Provider Name:
Provider Tax ID:
Provider Email:
Confirmation Email Address:
Medical Record Upload History
Click the "Expanded Upload History" button to see detailed Upload History
2 Medical Records were uploaded.
Most recent completed upload:
Document ID:
Claim:
Upload Date:
Expanded Upload History
Medical Record Request Letter
Please choose a claim from the list below
Document ID:
Submit
Help/Document ID lookup
I don't have a document ID
Claims:
Member
Patient Account Number:
Subscriber ID:
Member Name:
Member Date of Birth:
Date of Service (From date):
Date of Service (Thru date):
Medical Record File
Please choose the Medical Record File by clicking on 'Browse' button. Then Click 'Submit' button.
Note: If a password restriction has been placed on the document, please remove the restriction prior to upload.
Choose Medical Record File:
Browse...
Add Another File
Submit

If you do not have the Document ID, you can click on **I don't have Document ID** and you will allow to enter a claim ID number. After entering the Claim ID, all associated document IDs will show up. User can select the appropriate document ID or choose 'I don't know document ID' in case does not know the associated document ID number. These steps will auto populate the Member information and allow user to submit Medical Records via Medical Record File section. User can click to 'Add Another File' button to upload additional button. Users are allowed to submit up to five documents via clicking on '*Submit'* button.

Note: User may upload PDF, JPEG, TIFF or XML type of file format and maximum size of the file should not exceed more than 60MB.

User can view all the total numbers of Medical Records Upload and Most recent upload details via Medical Record Upload history. Clicking on '*Expand Upload History'* will show all previously uploaded documents by the user.


Medical Record Upload
Facility/Provider
To upload a Medical Record, please choose the Provider NPI from the menu. Please enter your email address to receive an email confirmation.
Provider/Facility Name
Provider Name:
Provider Tax ID:
Provider Email:
Confirmation Email Address:
Medical Record Upload History
Click the "Expanded Upload History" button to see detailed Upload History
20 Medical Records were uploaded.
Most recent completed upload:
Document ID:
Claim:
Upload Date:
Expanded Upload History
Medical Record Request Letter
Please type the Document ID that you have received in the Medical Record Letter, and then click the Submit button. If you cannot find the Document ID, please click on the 'Help/Document ID lookup' button below to open Medical Record Letter template.



You can filter the list by entering the upload "From" and "To" dates, then click on "Search". By clicking on '*Update'* button, user can change/update the previously submitted document. You can also export the Medical Upload History in excel document by clicking on "Export to Excel" button

For more information on how to use this specific feature, please go to Forms & Guides (by either clicking the main menu tab or the header tab on the dashboard landing page) and click the

'EMR Portal Guide' link found within the Manual and User Guide panel. Or simply click this link:
https://providerportal.careimprovementplus.com/pdf/XLHealth_EMR_Guide.pdf

3.5.2. Appeal/Reconsideration Upload

The Appeal/Reconsideration Upload module allows the users to electronically upload the documents to support the appeal & reconsideration request. This module automatically identifies the provider details as a part of provider portal account and hence, makes the appeal submission easier and faster. User can upload supporting documentation, submit manual routing request, view and update previous request and export previous submission history to excel for Appeal & Reconsideration activities.

CIP Provider users can submit the following types of requests and supporting documentation:

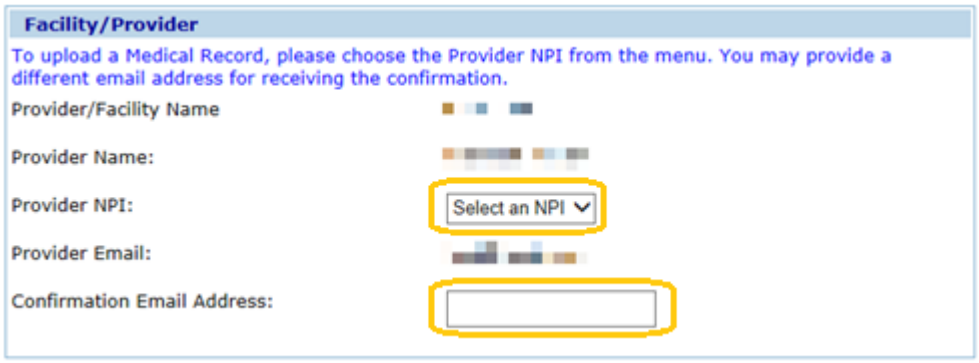
Requestor Type	Required Supporting Documents
Appeal	At least one of the following must be attached: Assignment of responsibility (AOR) Waiver of liability form (WOL) 1-5 additional documents
Reconsideration	1-5 additional documents (at least one document required)
Pre-Service	At least one of the following must be attached: Assignment of responsibility (AOR) Waiver of liability form (WOL) 1-5 additional documents

Clicking on Document Upload, you will see options for Medical Record Upload and Appeal/Reconsideration Request. To upload an Appeal and/or a Reconsideration documents, click on "Appeal/Reconsideration Request Upload" or "Click here to upload an Appeal/Reconsideration Request" link as shown in following figure.

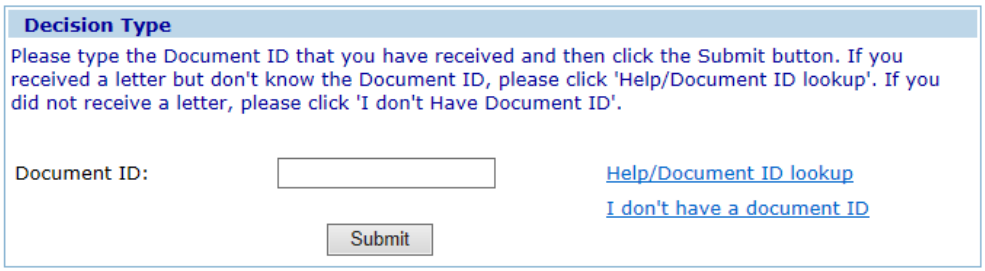
CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries
Home
Member Inquiry
Claim Center
Medicaid Info
Document Upload
Provider News
Forms & Guide
Reports
FAQs
Contact Us
Admin
Document Upload
Medical Record Upload
Care Improvement Plus requests medical records according to the guidelines set forth by CMS for fee-for-service Medicare. The Plan provides 30 calendar days for providers to fulfill each medical record request.
Click here to upload a Medical Record
Appeal/Reconsideration Request Upload
Providers may file a formal Appeal following an adverse determination with Care Improvement Plus. If a denial was issued due to missing/insufficient medical records, a Reconsideration request may be submitted; providers may supply missing medical records or additional documentation for consideration by the Plan.
Click here to upload an Appeal/Reconsideration Request

Clicking on "Appeal/Reconsideration Request" will open up appeal/reconsideration document upload module with pre populated information such as provider/facility name, provider name and provider email address associated with the account. If user's account is associated with multiple Tax ID/NPIs then user should select the one from the Provider Tax ID/NPI drop downs menu.

After selecting the Tax ID or NPI from the drop down menu '*Provider/Facility*' details and '*Appeal/Reconsideration History*' will show up. User can type in confirmation email address if wants to receive confirmation email on other than displayed email address.

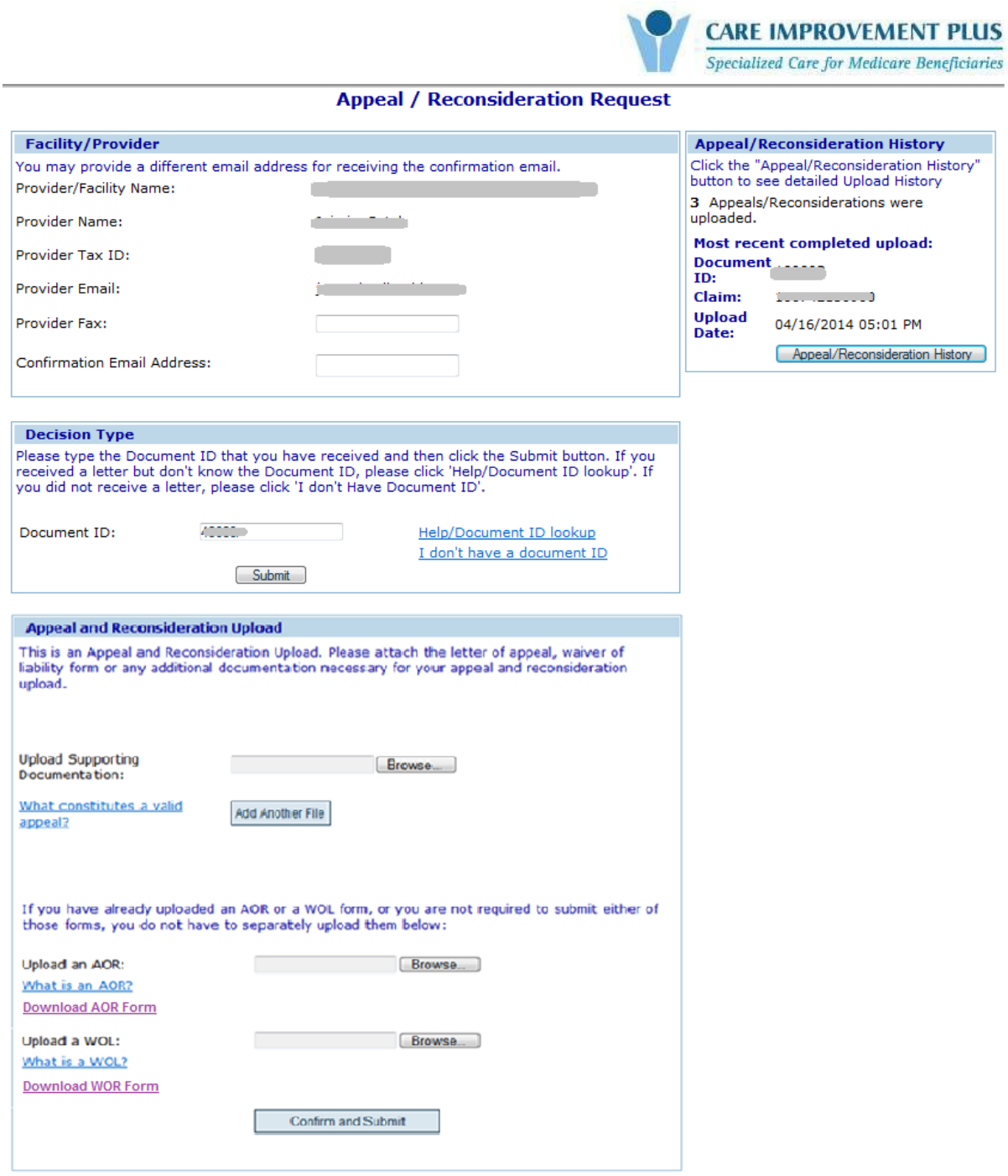

Facility/Provider
To upload a Medical Record, please choose the Provider NPI from the menu. You may provide a different email address for receiving the confirmation.
Provider/Facility Name
Provider Name:
Provider NPI:
Select an NPI
Provider Email:
Confirmation Email Address:

Type in the document ID number in the *Document ID* field and the member information will be populated. User can submit the related documents such as letter of appeal/reconsideration, waiver of liability (For non-par provider only) and additional documents through the Appeal/Reconsideration Documents Field.


Decision Type
Please type the Document ID that you have received and then click the Submit button. If you received a letter but don't know the Document ID, please click 'Help/Document ID lookup'. If you did not receive a letter, please click 'I don't Have Document ID'.
Document ID:
Help/Document ID lookup
I don't have a document ID
Submit

Submit Documents

User can browse, select the Appeal/Reconsideration letter and other supporting documents and submit them by clicking on '*Confirm and Submit*' button.


CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries
Appeal / Reconsideration Request
Facility/Provider
You may provide a different email address for receiving the confirmation email.
Provider/Facility Name:
Provider Name:
Provider Tax ID:
Provider Email:
Provider Fax:
Confirmation Email Address:
Appeal/Reconsideration History
Click the "Appeal/Reconsideration History" button to see detailed Upload History
3 Appeals/Reconsiderations were uploaded.
Most recent completed upload:
Document ID:
Claim:
Upload Date:
04/16/2014 05:01 PM
Appeal/Reconsideration History
Decision Type
Please type the Document ID that you have received and then click the Submit button. If you received a letter but don't know the Document ID, please click 'Help/Document ID lookup'. If you did not receive a letter, please click 'I don't Have Document ID'.
Document ID:
Help/Document ID lookup
I don't have a document ID
Submit
Appeal and Reconsideration Upload
This is an Appeal and Reconsideration Upload. Please attach the letter of appeal, waiver of liability form or any additional documentation necessary for your appeal and reconsideration upload.
Upload Supporting Documentation:
Browse...
What constitutes a valid appeal?
Add Another File
If you have already uploaded an AOR or a WOL form, or you are not required to submit either of those forms, you do not have to separately upload them below:
Upload an AOR:
Browse...
What is an AOR?
Download AOR Form
Upload a WOL:
Browse...
What is a WOL?
Download WOR Form
Confirm and Submit

If you do not have the Document ID or the decision letter, you can click on **I don't have Document ID** and you will allow to enter a claim ID number. You can look up the document ID with the date of service plus one of the following.

1. HICN
2. Member Name and Date of Birth

3. Subscriber ID

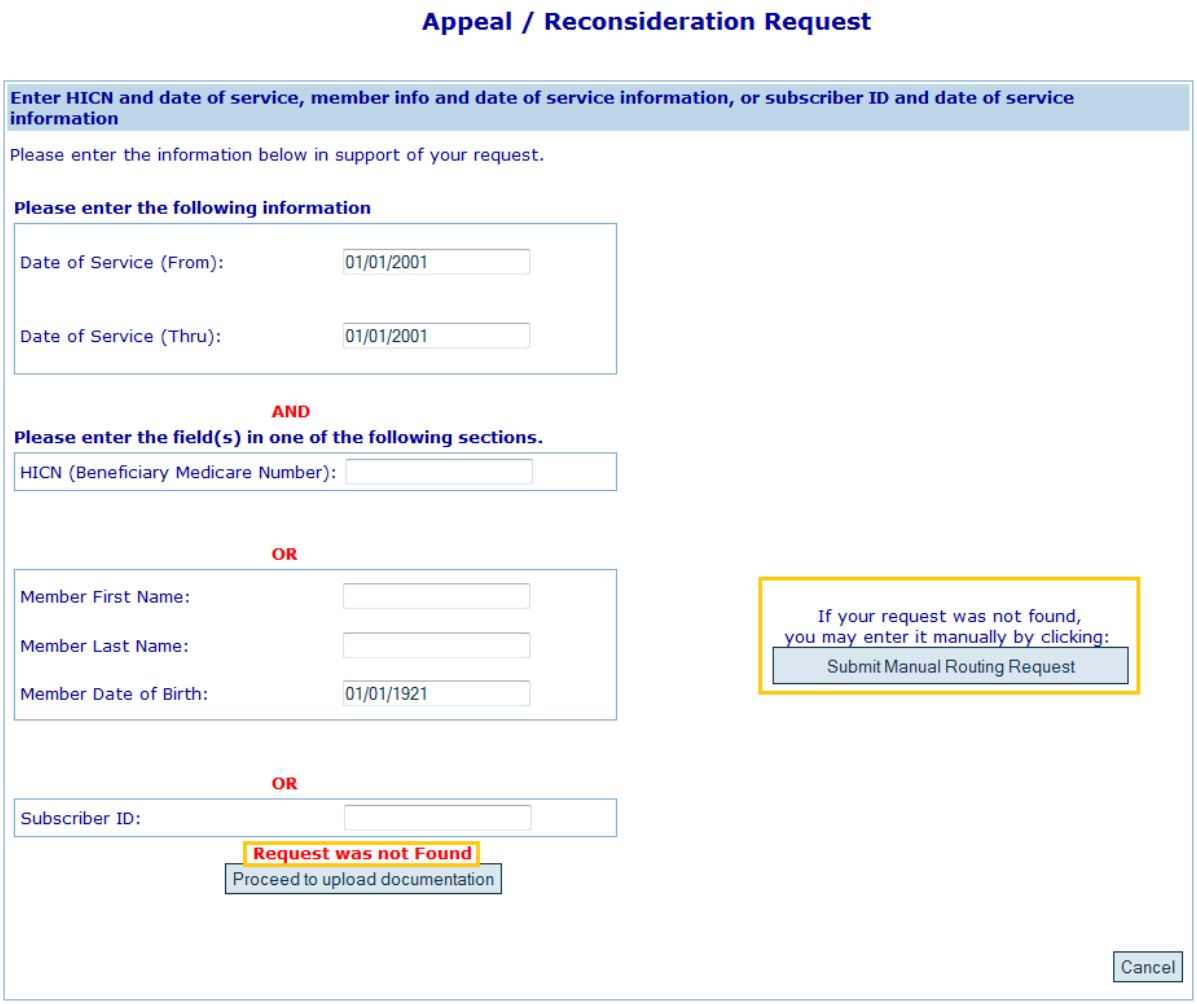
Note: If you are unable to locate or look up the document ID number using other information, you can submit a manual routing request. For more information, see the "Submit a Manual Routing Request" procedure at end of this section.

After entering the document ID or proceeding through "I don't have document ID", you can proceed to document upload and browse for the document, select the Appeal/Reconsideration letter and other supporting documents and submit them by clicking on '*Confirm and Submit*' button.

Note: User may upload PDF, JPEG, TIFF or XML type of file format and maximum size of the file should not exceed more than 60MB.

Submit a Manual Routing request

If your request was not found when you search for the document ID via “I don’t have document ID” within two attempts, an option to submit a manual routing request will appear at the bottom of the page. Click on “Submit Manual Routing Request” to begin.


Appeal / Reconsideration Request
Enter HICN and date of service, member info and date of service information, or subscriber ID and date of service information
Please enter the information below in support of your request.
Please enter the following information
Date of Service (From):
01/01/2001
Date of Service (Thru):
01/01/2001
AND
Please enter the field(s) in one of the following sections.
HICN (Beneficiary Medicare Number):
OR
Member First Name:
Member Last Name:
Member Date of Birth:
01/01/1921
OR
Subscriber ID:
Request was not Found
Proceed to upload documentation
If your request was not found, you may enter it manually by clicking:
Submit Manual Routing Request
Cancel

Click the “Submit Manual Routing Request” button and Manual Routing Request module will open up. Enter the information about the request type, member and date of service then click “Proceed to upload documentation”.

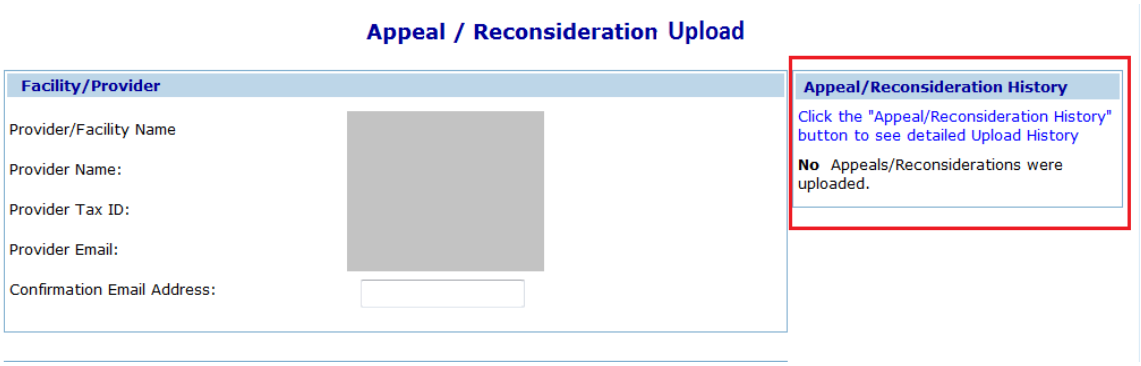
Appeal / Reconsideration Request
Manual Routing Request
Please be advised that you are submitting manual Appeal/Reconsideration request. A team member will review your request within 72 hours if your request is Expedited-PreService appeal. Otherwise, you will receive a reply within 30 days. Please enter one of the following combinations below: a) HICN and dates of service, b) first name, last name, date of birth and dates of service, c) Subscriber ID and dates of service.
Request Type:
Pre-Service
Doc_ID:
Subscriber ID:
HICN (Beneficiary Medicare Number):
Member First Name:
Member Last Name:
Member Date of Birth:
MM/DD/YYYY
Date of Service (From Date):
MM/DD/YYYY
Date of Service (Thru Date):
MM/DD/YYYY
Pre-Service Expedited Appeal
Proceed to upload documentation
Cancel

Upload documentation and submit. For more information, see the “Submit Documents” on previous section.

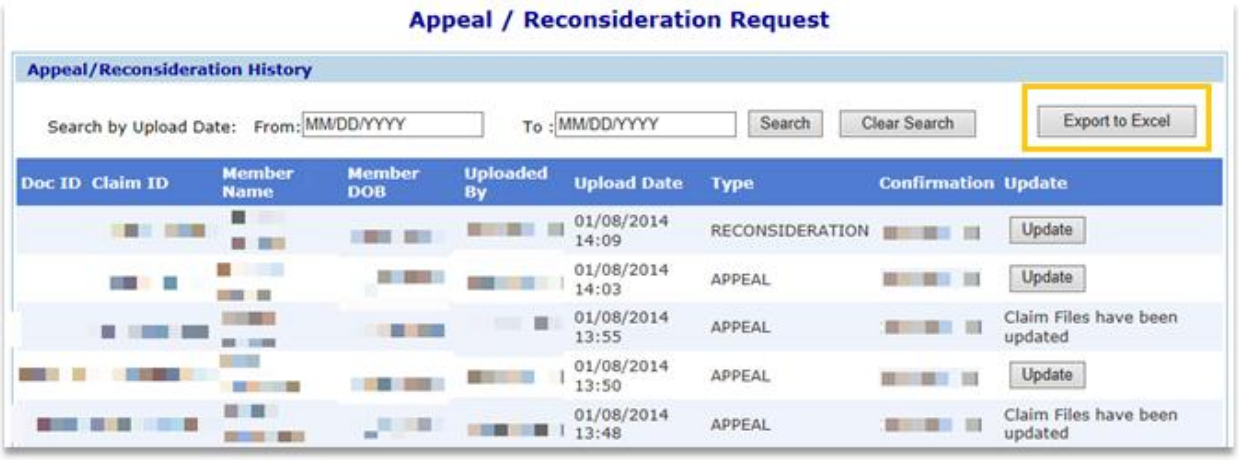
Appeal/Reconsideration History

User can view all the total numbers of Appeal/Reconsideration document Upload and Most recent upload details via Appeal/Reconsideration history. Clicking on ‘*Appeal Reconsideration History’* will show all previously uploaded documents by the user.

The Appeal/Reconsideration history section allows the user to update previously uploaded appeals or reconsideration documents. Once a document is uploaded, the provider is given a new confirmation number with a revised date for the date of submission for the appeal/reconsideration.



You can also export the “Appeal Submission History” to excel file by using ‘Export to Excel’ button.

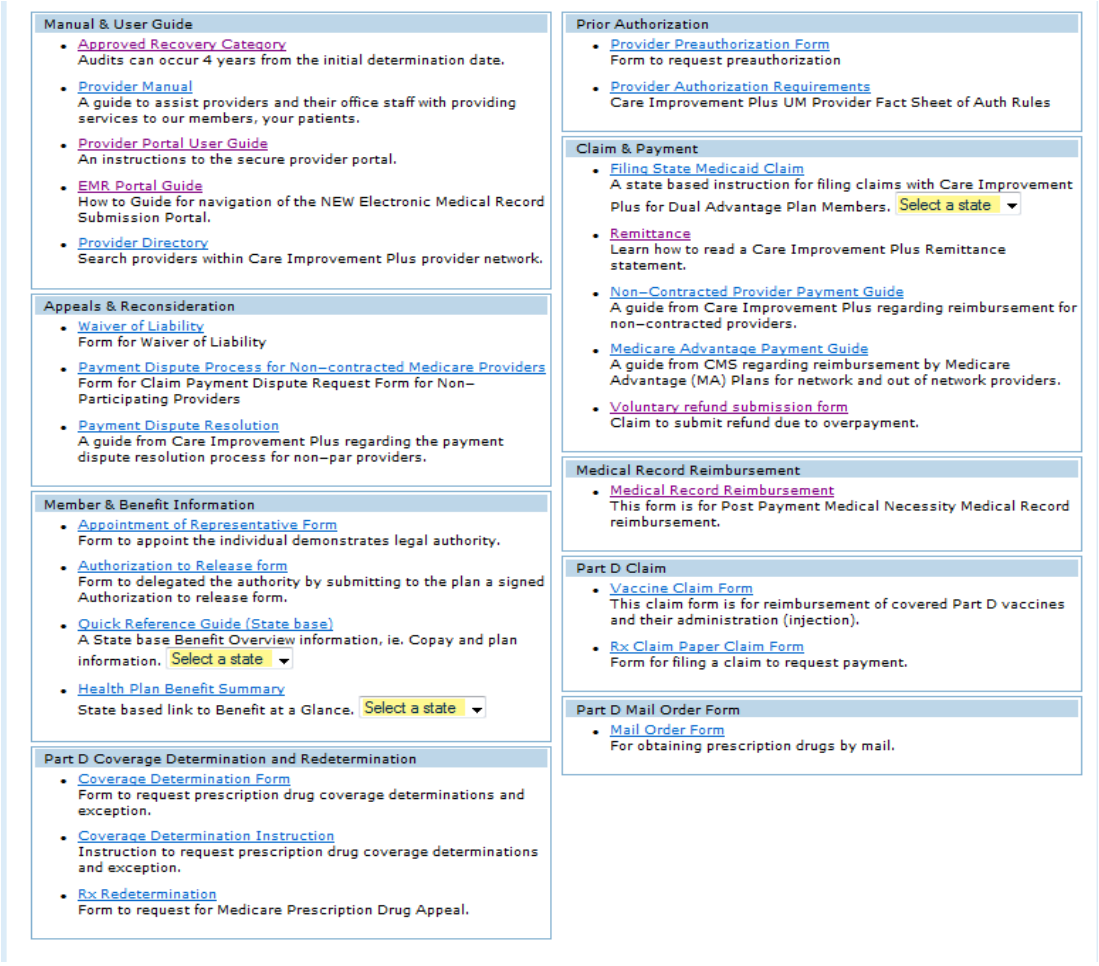


3.6 Provider News

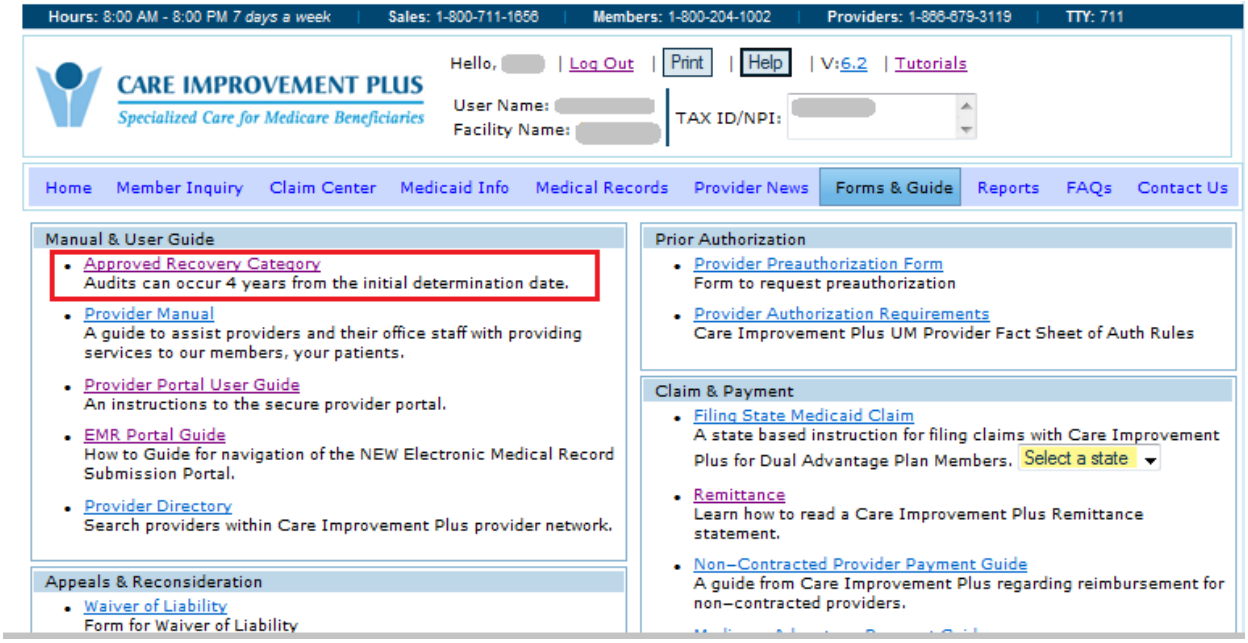
The most recent updates/news items will display in this section. The Top 5 most recent news items will display in this panel, and clicking any of these will open the news detail as a PDF document. Clicking the header of the Provider News panel or the Provider News main menu tab will open the public Provider Portal News section in a new browser window and display all news items.

3.7 Forms & Guides

Provides all forms and guides related to Manual & User Guide, Appeals & Reconsideration, Prior Authorization, Claims & Payments, Medical Record Reimbursement, Member & Benefit Information, Part D Claim, Part D Coverage Determination and Redetermination, and Part D Mail Order Form.


Manual & User Guide
Approved Recovery Category
Audits can occur 4 years from the initial determination date.
Provider Manual
A guide to assist providers and their office staff with providing services to our members, your patients.
Provider Portal User Guide
An instructions to the secure provider portal.
EMR Portal Guide
How to Guide for navigation of the NEW Electronic Medical Record Submission Portal.
Provider Directory
Search providers within Care Improvement Plus provider network.
Appeals & Reconsideration
Waiver of Liability
Form for Waiver of Liability
Payment Dispute Process for Non–contracted Medicare Providers
Form for Claim Payment Dispute Request Form for Non–Participating Providers
Payment Dispute Resolution
A guide from Care Improvement Plus regarding the payment dispute resolution process for non–par providers.
Member & Benefit Information
Appointment of Representative Form
Form to appoint the individual demonstrates legal authority.
Authorization to Release form
Form to delegated the authority by submitting to the plan a signed Authorization to release form.
Quick Reference Guide (State base)
A State base Benefit Overview information, ie. Copay and plan information. Select a state
Health Plan Benefit Summary
State based link to Benefit at a Glance. Select a state
Part D Coverage Determination and Redetermination
Coverage Determination Form
Form to request prescription drug coverage determinations and exception.
Coverage Determination Instruction
Instruction to request prescription drug coverage determinations and exception.
Rx Redetermination
Form to request for Medicare Prescription Drug Appeal.
Prior Authorization
Provider Preauthorization Form
Form to request preauthorization
Provider Authorization Requirements
Care Improvement Plus UM Provider Fact Sheet of Auth Rules
Claim & Payment
Filing State Medicaid Claim
A state based instruction for filing claims with Care Improvement Plus for Dual Advantage Plan Members. Select a state
Remittance
Learn how to read a Care Improvement Plus Remittance statement.
Non–Contracted Provider Payment Guide
A guide from Care Improvement Plus regarding reimbursement for non–contracted providers.
Medicare Advantage Payment Guide
A guide from CMS regarding reimbursement by Medicare Advantage (MA) Plans for network and out of network providers.
Voluntary refund submission form
Claim to submit refund due to overpayment.
Medical Record Reimbursement
Medical Record Reimbursement
This form is for Post Payment Medical Necessity Medical Record reimbursement.
Part D Claim
Vaccine Claim Form
This claim form is for reimbursement of covered Part D vaccines and their administration (injection).
Rx Claim Paper Claim Form
Form for filing a claim to request payment.
Part D Mail Order Form
Mail Order Form
For obtaining prescription drugs by mail.

- Selecting a state from the state drop-down boxes will display specific information relevant to those states.
- The Forms & Guide section has the new feature listed as *Approved Recovery Category* under the section “Manual and User Guide”.


Hours: 8:00 AM - 8:00 PM 7 days a week
Sales: 1-800-711-1656
Members: 1-800-204-1002
Providers: 1-866-679-3119
TTY: 711
CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries
Hello,
Log Out
Print
Help
V:6.2
Tutorials
User Name:
Facility Name:
TAX ID/NPI:
Home
Member Inquiry
Claim Center
Medicaid Info
Medical Records
Provider News
Forms & Guide
Reports
FAQs
Contact Us
Manual & User Guide
Approved Recovery Category
Audits can occur 4 years from the initial determination date.
Provider Manual
A guide to assist providers and their office staff with providing services to our members, your patients.
Provider Portal User Guide
An instructions to the secure provider portal.
EMR Portal Guide
How to Guide for navigation of the NEW Electronic Medical Record Submission Portal.
Provider Directory
Search providers within Care Improvement Plus provider network.
Appeals & Reconsideration
Waiver of Liability
Form for Waiver of Liability
Prior Authorization
Provider Preauthorization Form
Form to request preauthorization
Provider Authorization Requirements
Care Improvement Plus UM Provider Fact Sheet of Auth Rules
Claim & Payment
Filing State Medicaid Claim
A state based instruction for filing claims with Care Improvement Plus for Dual Advantage Plan Members.
Select a state
Remittance
Learn how to read a Care Improvement Plus Remittance statement.
Non–Contracted Provider Payment Guide
A guide from Care Improvement Plus regarding reimbursement for non–contracted providers.

- This section provides the information about the Audit Concept, Recovery Type, Claim Type, Implementation Date and Description of the Audit. By using this link, the user can look back over 4 years of review data from the current date.

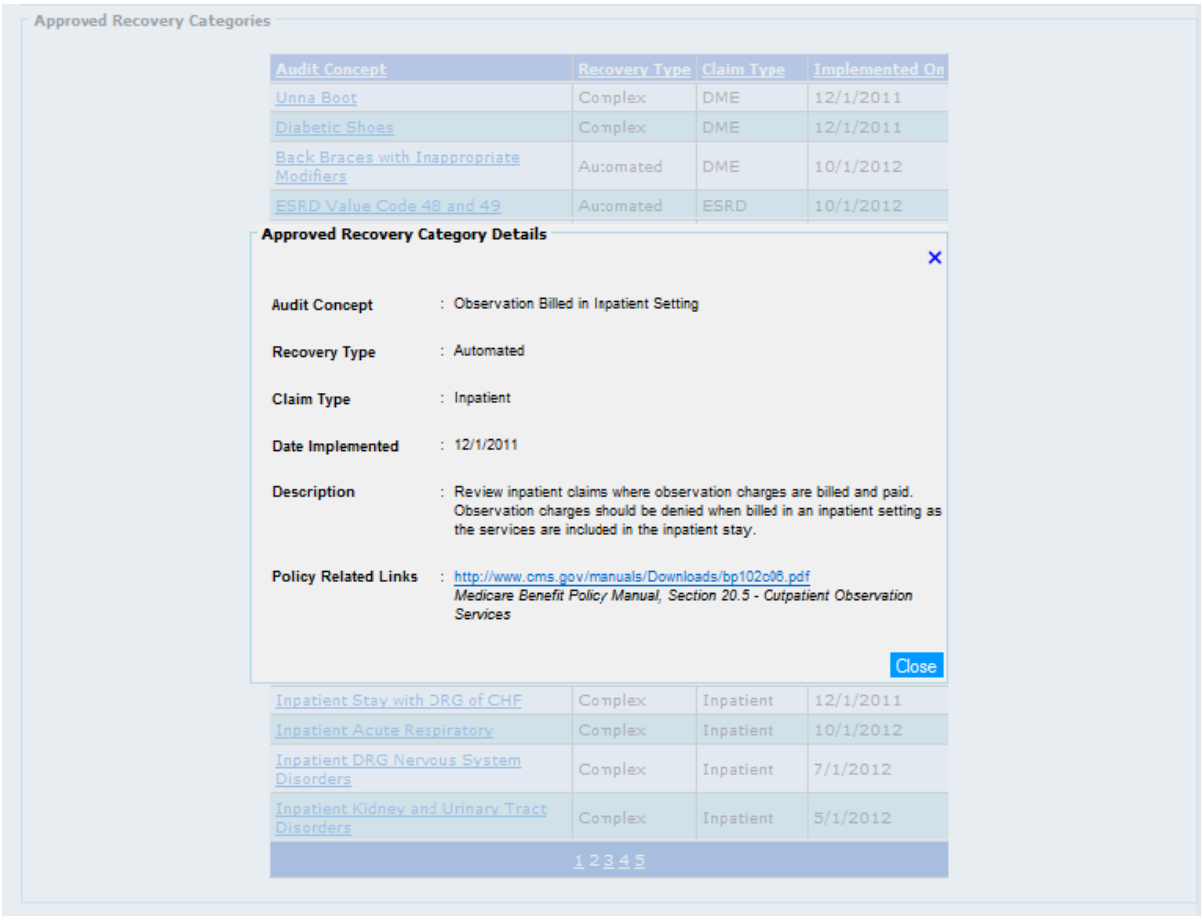
- The user can also sort the list alphabetically by clicking on a specific column title to change the default order of items listed by Audit Concept, and the *Implementation date* column can be sorted chronologically. To jump to another page, please click on the pagination on bottom of the table. Please refer to the following image.

Approved Recovery Categories

Audit Concept	Recovery Type	Claim Type	Implemented On
Acupuncture Paid Claims	Automated	Professional	11/1/2011
Add On Codes for Same Physician	Automated	Professional	12/1/2011
Age Inappropriate Services	Automated	All	12/1/2011
Anesthesia Overpaid Claims	Automated	Professional	10/1/2010
Annual Wellness Visit (AWV) Overpayments	Automated	Professional	6/1/2013
Arthritis Kits	**Complex**	**Professional/DME**	**11/1/2009**
Back Braces with Inappropriate Modifiers	Automated	DME	10/1/2012
Bone Growth Stimulators	Complex	DME	12/1/2011
Claims Billed on HCFA 1500 and UB04	Automated	All	12/1/2011
Cosmetic Surgery Covered Services	Complex	Outpatient/Inpatient/Professional	12/1/2011
CPAP Without Sleep Apnea Test or DX	Complex	DME	12/1/2011
CT & MRI Imaging Procedures With and Without Contrast	Complex	Outpatient/Professional	12/1/2011
Diabetic Shoes	Complex	DME	12/1/2011
Diagnostic Services with no Physician Visit	Complex	Outpatient/Professional	12/1/2011
DME Unlisted Procedure	Automated	DME	1/1/2012
Doctors Working Weekends	Complex	Professional	12/1/2011
E & M Upcoding	Complex	Professional	12/1/2011
E&M Crosswalk	Automated	Professional	12/1/2011
E&M Same Day as Debridement	Complex	Professional	1/1/2013
Emergency Ambulance no Medical Claim	Complex	Ambulance	5/1/2010

1 2 3 4 5

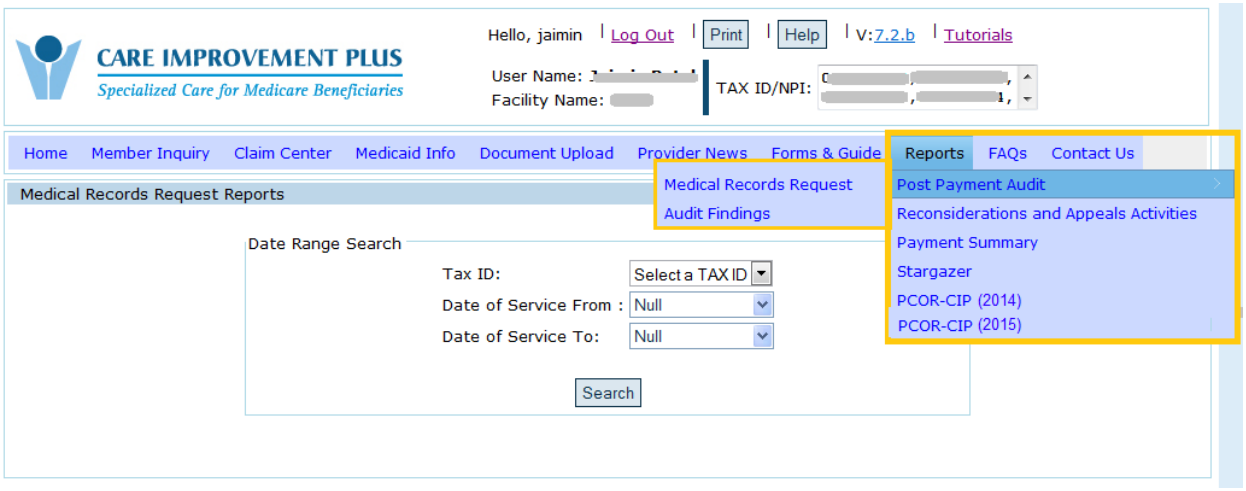
- Click on any of the Audit Concept list links and a new window will open up with the details of the recovery category, along with Policy Related Links (if any exist). To return back to the Approved Recovery Categories list view page, simply click on the close button or the ‘X’ icon located on the top-right corner of the box.



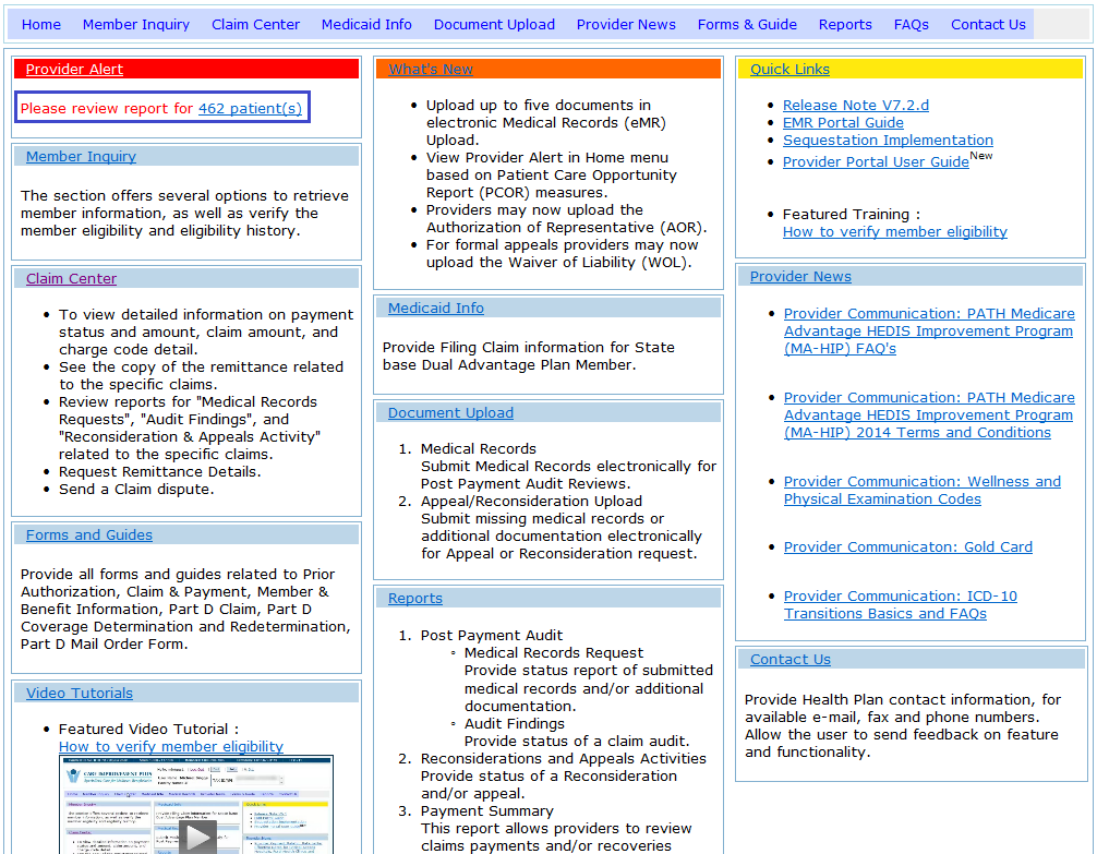
3.8 Reports

This page gives the user the ability to view five medical report types: **Medical Records Request, Audit Findings, Reconsiderations and Appeals Activity, Payment Summary and the Stargazer report**. If data is available for these reports, it will display in a lookup table once a report button is clicked.

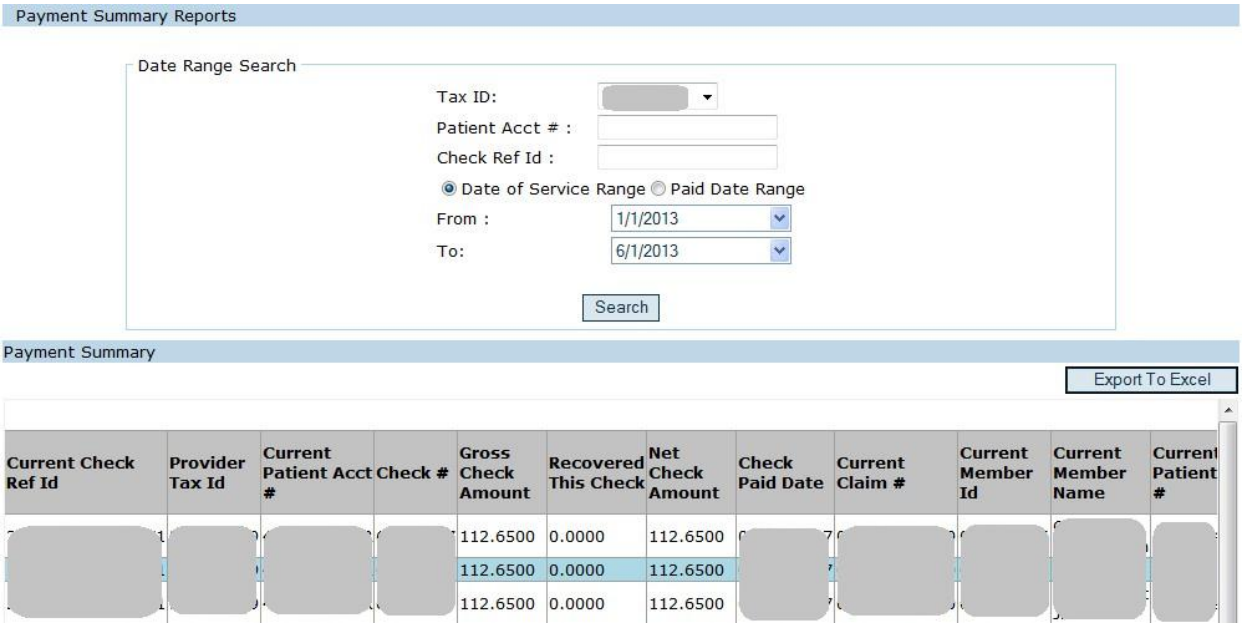
This page can be accessed from the main menu by clicking the Reports tab, or from the Reports dashboard on the home page.



Providers can also access the ***2015 PCOR report*** from the main menu by clicking on the patient numbers under the Provider Alert section on the home page. Please review the *Patient Care Opportunity Report (PCOR)* section for more details.


Home
Member Inquiry
Claim Center
Medicaid Info
Document Upload
Provider News
Forms & Guide
Reports
FAQs
Contact Us
Provider Alert
Please review report for 462 patient(s)
Member Inquiry
The section offers several options to retrieve member information, as well as verify the member eligibility and eligibility history.
Claim Center
To view detailed information on payment status and amount, claim amount, and charge code detail.
See the copy of the remittance related to the specific claims.
Review reports for "Medical Records Requests", "Audit Findings", and "Reconsideration & Appeals Activity" related to the specific claims.
Request Remittance Details.
Send a Claim dispute.
Forms and Guides
Provide all forms and guides related to Prior Authorization, Claim & Payment, Member & Benefit Information, Part D Claim, Part D Coverage Determination and Redetermination, Part D Mail Order Form.
Video Tutorials
Featured Video Tutorial :
How to verify member eligibility
What's New
Upload up to five documents in electronic Medical Records (eMR) Upload.
View Provider Alert in Home menu based on Patient Care Opportunity Report (PCOR) measures.
Providers may now upload the Authorization of Representative (AOR).
For formal appeals providers may now upload the Waiver of Liability (WOL).
Medicaid Info
Provide Filing Claim information for State base Dual Advantage Plan Member.
Document Upload
1. Medical Records
Submit Medical Records electronically for Post Payment Audit Reviews.
2. Appeal/Reconsideration Upload
Submit missing medical records or additional documentation electronically for Appeal or Reconsideration request.
Reports
1. Post Payment Audit
Medical Records Request
Provide status report of submitted medical records and/or additional documentation.
Audit Findings
Provide status of a claim audit.
2. Reconsiderations and Appeals Activities
Provide status of a Reconsideration and/or appeal.
3. Payment Summary
This report allows providers to review claims payments and/or recoveries
Quick Links
Release Note V7.2.d
EMR Portal Guide
Sequestation Implementation
Provider Portal User Guide New
Featured Training :
How to verify member eligibility
Provider News
Provider Communication: PATH Medicare Advantage HEDIS Improvement Program (MA-HIP) FAQ's
Provider Communication: PATH Medicare Advantage HEDIS Improvement Program (MA-HIP) 2014 Terms and Conditions
Provider Communication: Wellness and Physical Examination Codes
Provider Communicaton: Gold Card
Provider Communication: ICD-10 Transitions Basics and FAQs
Contact Us
Provide Health Plan contact information, for available e-mail, fax and phone numbers. Allow the user to send feedback on feature and functionality.

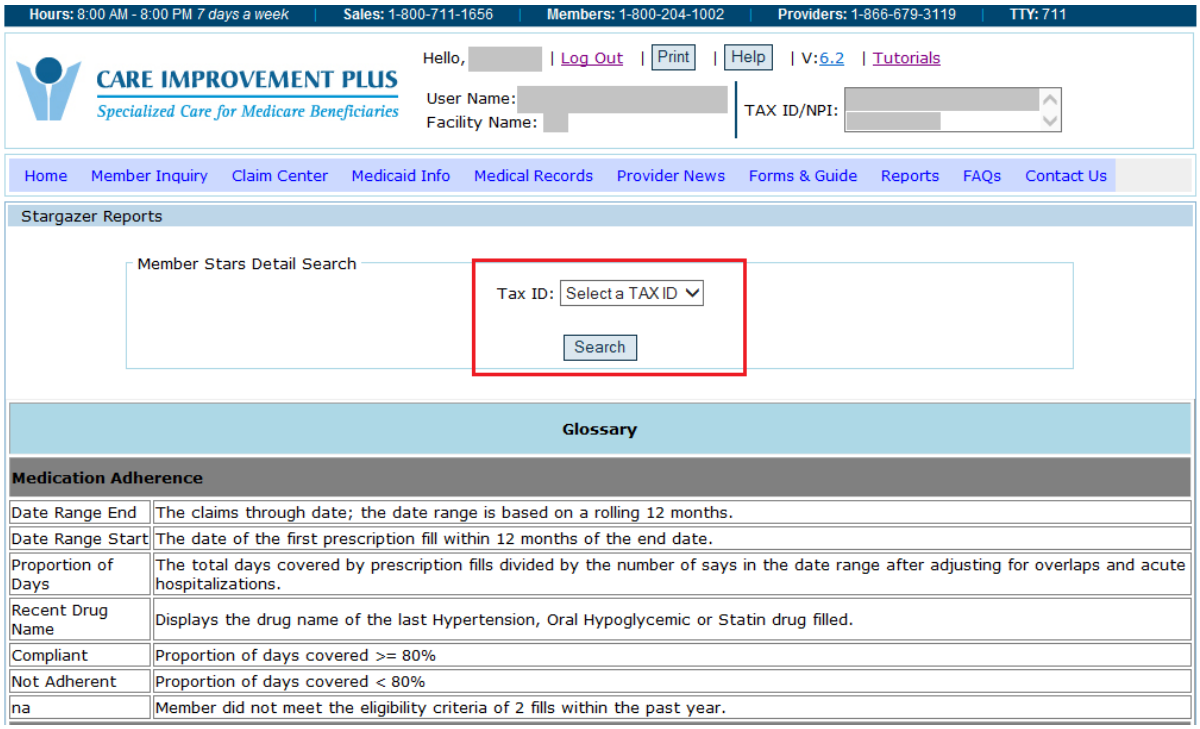
- To access either the Medical Requests or Audit Findings Reports, simply hover over the Post Payment Audit sub-menu field as shown in the picture in previous page. You will then arrive on the Reports search page, with criteria in which to search for reports. A provider user must select one of the Tax ID or NPI numbers they are assigned to in the application first.



- The Payment Summary Report is a unique report type that allows you to search by a specific Patient Account number or Check Reference ID, along with the Tax ID or NPI number. Users must also select a date range, either by the Date of Service or by date the check was processed and paid for.

- Users have the option to export and save the information into an Excel document. The data is displayed in the excel sheet by table column and in the same order as it appears within the application.

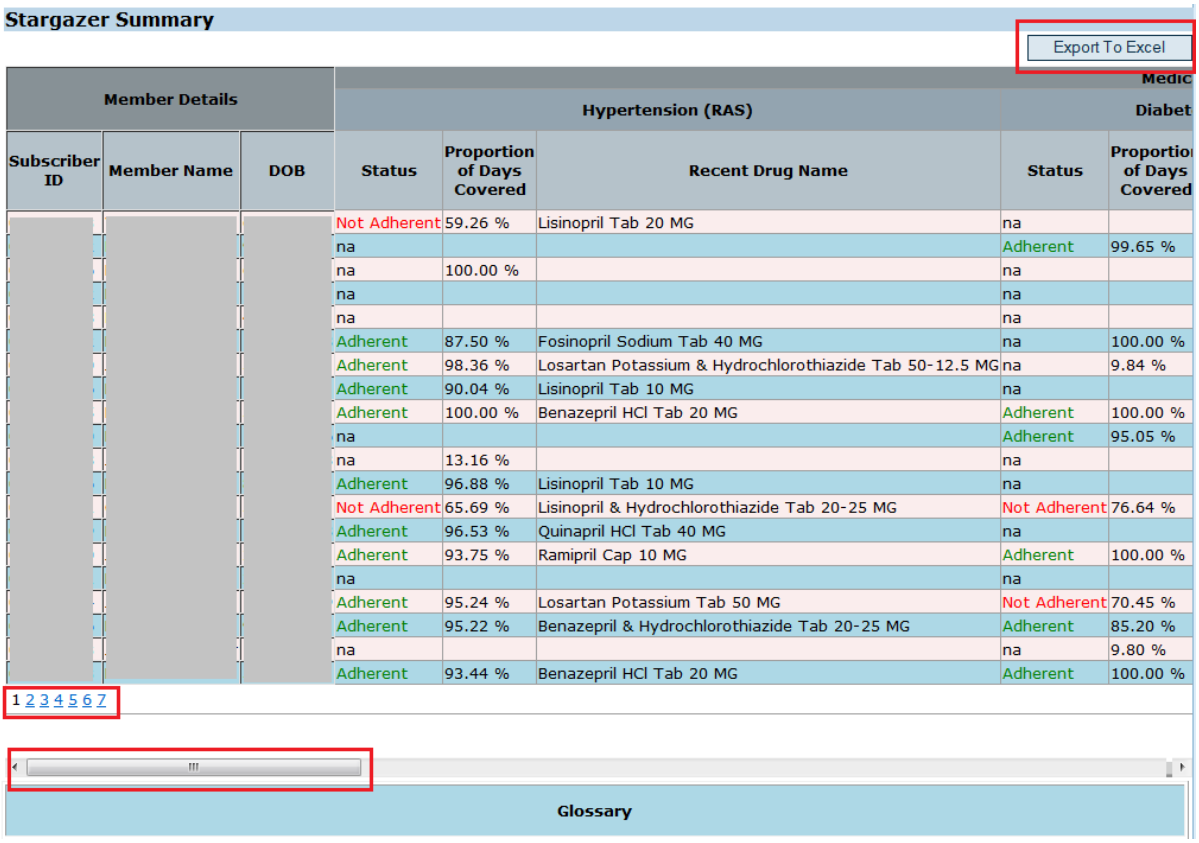
Stargazer Report: The Provider Portal will display any members which are assigned to their office, and each member will have a column for a specific measure. Based on the contents of each column will determine the action required for each member. Provider user can search the Member Stars Detail by selecting the associated TAX ID or NPI and then clicking on the *Search* button.



Glossary	
Medication Adherence	
Date Range End	The claims through date; the date range is based on a rolling 12 months.
Date Range Start	The date of the first prescription fill within 12 months of the end date.
Proportion of Days	The total days covered by prescription fills divided by the number of says in the date range after adjusting for overlaps and acute hospitalizations.
Recent Drug Name	Displays the drug name of the last Hypertension, Oral Hypoglycemic or Statin drug filled.
Compliant	Proportion of days covered >= 80%
Not Adherent	Proportion of days covered < 80%
na	Member did not meet the eligibility criteria of 2 fills within the past year.

If a member is Non-Compliant that indicates the member has not received the required screening or test for that required measure. If a member is listed as Compliant, the member has met all requirements and requires no action. If a "-" or "na" is listed the member does not qualify for that measure and does not require and action. User can find the *Glossary* on bottom of the table for detailed explanation about the terms.

- User can scroll the report horizontally through the scrollbar and also jump to another page by clicking on the page number located below the table. Another feature under the *Stargazer Summary* is *Export to Excel*. This button allows you to save and print an excel spreadsheet of members you received in your Search Results.



Stargazer Summary

Export To Excel

Member Details			Hypertension (RAS)			Medic Diabet	
Subscriber ID	Member Name	DOB	Status	Proportion of Days Covered	Recent Drug Name	Status	Proportio of Days Covered
			Not Adherent	59.26 %	Lisinopril Tab 20 MG	na	
			na			Adherent	99.65 %
			na	100.00 %		na	
			na			na	
			na			na	
			Adherent	87.50 %	Fosinopril Sodium Tab 40 MG	na	100.00 %
			Adherent	98.36 %	Losartan Potassium & Hydrochlorothiazide Tab 50-12.5 MG	na	9.84 %
			Adherent	90.04 %	Lisinopril Tab 10 MG	na	
			Adherent	100.00 %	Benazepril HCl Tab 20 MG	Adherent	100.00 %
			na			Adherent	95.05 %
			na	13.16 %		na	
			Adherent	96.88 %	Lisinopril Tab 10 MG	na	
			Not Adherent	65.69 %	Lisinopril & Hydrochlorothiazide Tab 20-25 MG	Not Adherent	76.64 %
			Adherent	96.53 %	Quinapril HCl Tab 40 MG	na	
			Adherent	93.75 %	Ramipril Cap 10 MG	Adherent	100.00 %
			na			na	
			Adherent	95.24 %	Losartan Potassium Tab 50 MG	Not Adherent	70.45 %
			Adherent	95.22 %	Benazepril & Hydrochlorothiazide Tab 20-25 MG	Adherent	85.20 %
			na			na	9.80 %
			Adherent	93.44 %	Benazepril HCl Tab 20 MG	Adherent	100.00 %

1 2 3 4 5 6 7

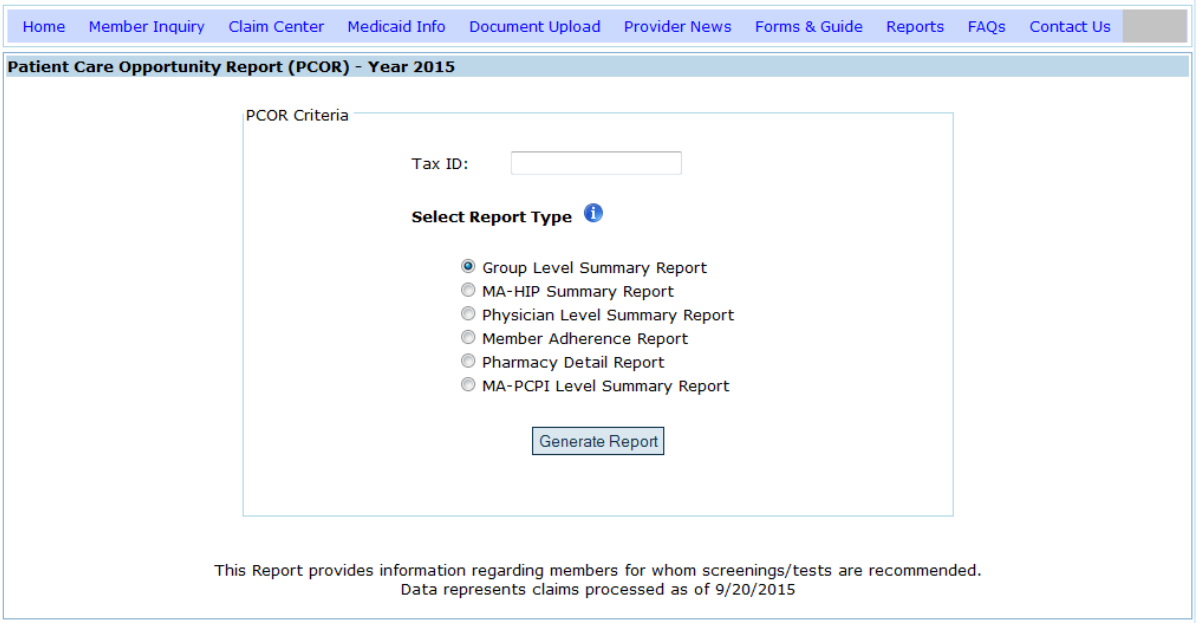
Glossary

Patient Care Opportunity Report (PCOR):

Patient Care Opportunity Report for CIP members provides information regarding members where screenings or tests are recommended. User can access different types of reports under PCOR.

1. Group Level Summary Report
2. MA-HIP Summary Report (Not available for year 2014)
3. Physician Level Summary Report
4. Member Adherence Report
5. Pharmacy Detail Report
6. MA-PCPi Level Summary Report (Not available for year 2014)

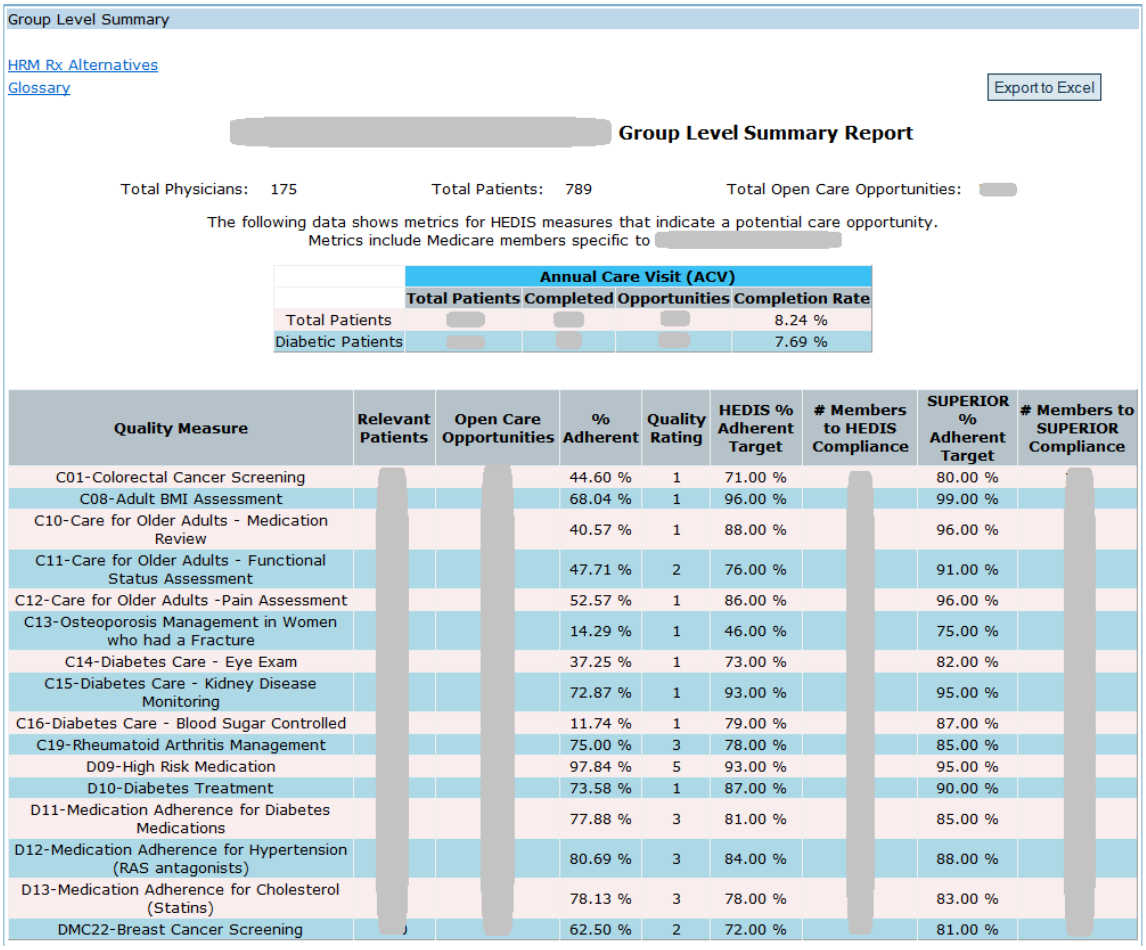
Note: Images in this section are showing data for year 2015. PCOR report for year 2014 may have slightly different data.



User can select the Tax ID and report type and click on generate report. These reports can be export to excel sheet by using ‘ Export to Excel’ button located on top right corner of each report. This button allows you to save and print an excel spreadsheet of members you received in your Search Results. User can also view the High-Risk Medication Alternatives and glossary for this report, located at top left corner of the each report.

User can scroll the report horizontally through the scrollbar and also jump to another page by clicking on the page number located below the table.

- **Group Level Summary Report**
  Summarizes by group (TIN) the number of members for each recommended HEDIS measure. Additionally, current and prior reporting period compliance as well as current STAR rating is provided. Quality Outcomes and Clinical Performance represent performance based on HEDIS and/or STAR specifications.



Group Level Summary

HRM Rx Alternatives
Glossary

Export to Excel

[redacted] Group Level Summary Report

Total Physicians: 175 Total Patients: 789 Total Open Care Opportunities: [redacted]

The following data shows metrics for HEDIS measures that indicate a potential care opportunity.
Metrics include Medicare members specific to [redacted]

	Annual Care Visit (ACV)			
	Total Patients	Completed Opportunities		Completion Rate
Total Patients	[redacted]	[redacted]	[redacted]	8.24 %
Diabetic Patients	[redacted]	[redacted]	[redacted]	7.69 %

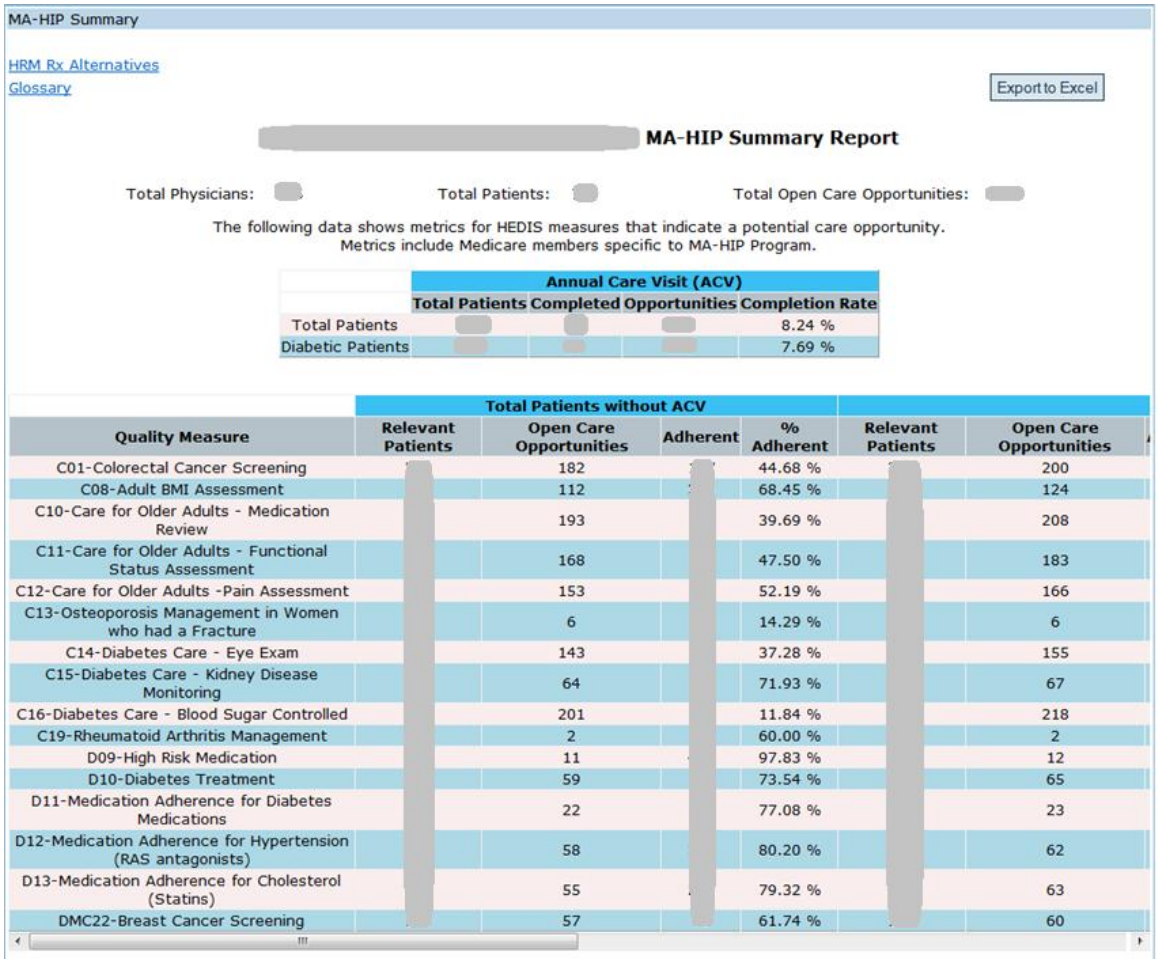
Quality Measure	Relevant Patients	Open Care Opportunities	% Adherent	Quality Rating	HEDIS % Adherent Target	# Members to HEDIS Compliance	SUPERIOR % Adherent Target	# Members to SUPERIOR Compliance
C01-Colorectal Cancer Screening	[redacted]	[redacted]	44.60 %	1	71.00 %	[redacted]	80.00 %	[redacted]
C08-Adult BMI Assessment			68.04 %	1	96.00 %		99.00 %	
C10-Care for Older Adults - Medication Review			40.57 %	1	88.00 %		96.00 %	
C11-Care for Older Adults - Functional Status Assessment			47.71 %	2	76.00 %		91.00 %	
C12-Care for Older Adults -Pain Assessment			52.57 %	1	86.00 %		96.00 %	
C13-Osteoporosis Management in Women who had a Fracture			14.29 %	1	46.00 %		75.00 %	
C14-Diabetes Care - Eye Exam			37.25 %	1	73.00 %		82.00 %	
C15-Diabetes Care - Kidney Disease Monitoring			72.87 %	1	93.00 %		95.00 %	
C16-Diabetes Care - Blood Sugar Controlled			11.74 %	1	79.00 %		87.00 %	
C19-Rheumatoid Arthritis Management			75.00 %	3	78.00 %		85.00 %	
D09-High Risk Medication			97.84 %	5	93.00 %		95.00 %	
D10-Diabetes Treatment			73.58 %	1	87.00 %		90.00 %	
D11-Medication Adherence for Diabetes Medications			77.88 %	3	81.00 %		85.00 %	
D12-Medication Adherence for Hypertension (RAS antagonists)			80.69 %	3	84.00 %		88.00 %	
D13-Medication Adherence for Cholesterol (Statins)			78.13 %	3	78.00 %		83.00 %	
DMC22-Breast Cancer Screening			62.50 %	2	72.00 %		81.00 %	

This report displays important information about total number of physicians within the provider group assigned (or attributed) as the PCP for a member, and total number of members with an assigned PCP that is part of the provider group (Total Patients). This report also gives detail summary of number of Patients for relevant Quality Measures, open care opportunities, Non Adherent and Adherent percentage, Prior Adherent Reporting Period percentage, Adherent Trend, Quality Rating and Adherence Target percentage.

- **MA-HIP Summary Report**

  Summarizes the MA-HIP membership for each recommended HEDIS and Part D measure, as well as whether the quality targets have been met and a summary view of Annual Care Visit performance. Additionally, the number of

members eligible for the screening as well as current and prior reporting period compliance is shown with the number of members required to reach HEDIS and SUPERIOR adherence rates included. Quality Outcomes and Clinical Performance represent performance based on HEDIS and/or STAR specifications.



MA-HIP Summary

HRM Rx Alternatives
Glossary

Export to Excel

[redacted] MA-HIP Summary Report

Total Physicians: [redacted] Total Patients: [redacted] Total Open Care Opportunities: [redacted]

The following data shows metrics for HEDIS measures that indicate a potential care opportunity.
Metrics include Medicare members specific to MA-HIP Program.

	Annual Care Visit (ACV)			
	Total Patients	Completed Opportunities		Completion Rate
Total Patients	[redacted]	[redacted]	[redacted]	8.24 %
Diabetic Patients	[redacted]	[redacted]	[redacted]	7.69 %

	Total Patients without ACV					
Quality Measure	Relevant Patients	Open Care Opportunities	Adherent	% Adherent	Relevant Patients	Open Care Opportunities
C01-Colorectal Cancer Screening	[redacted]	182	[redacted]	44.68 %	[redacted]	200
C08-Adult BMI Assessment	[redacted]	112	[redacted]	68.45 %	[redacted]	124
C10-Care for Older Adults - Medication Review	[redacted]	193	[redacted]	39.69 %	[redacted]	208
C11-Care for Older Adults - Functional Status Assessment	[redacted]	168	[redacted]	47.50 %	[redacted]	183
C12-Care for Older Adults -Pain Assessment	[redacted]	153	[redacted]	52.19 %	[redacted]	166
C13-Osteoporosis Management in Women who had a Fracture	[redacted]	6	[redacted]	14.29 %	[redacted]	6
C14-Diabetes Care - Eye Exam	[redacted]	143	[redacted]	37.28 %	[redacted]	155
C15-Diabetes Care - Kidney Disease Monitoring	[redacted]	64	[redacted]	71.93 %	[redacted]	67
C16-Diabetes Care - Blood Sugar Controlled	[redacted]	201	[redacted]	11.84 %	[redacted]	218
C19-Rheumatoid Arthritis Management	[redacted]	2	[redacted]	60.00 %	[redacted]	2
D09-High Risk Medication	[redacted]	11	[redacted]	97.83 %	[redacted]	12
D10-Diabetes Treatment	[redacted]	59	[redacted]	73.54 %	[redacted]	65
D11-Medication Adherence for Diabetes Medications	[redacted]	22	[redacted]	77.08 %	[redacted]	23
D12-Medication Adherence for Hypertension (RAS antagonists)	[redacted]	58	[redacted]	80.20 %	[redacted]	62
D13-Medication Adherence for Cholesterol (Statins)	[redacted]	55	[redacted]	79.32 %	[redacted]	63
DMC22-Breast Cancer Screening	[redacted]	57	[redacted]	61.74 %	[redacted]	60

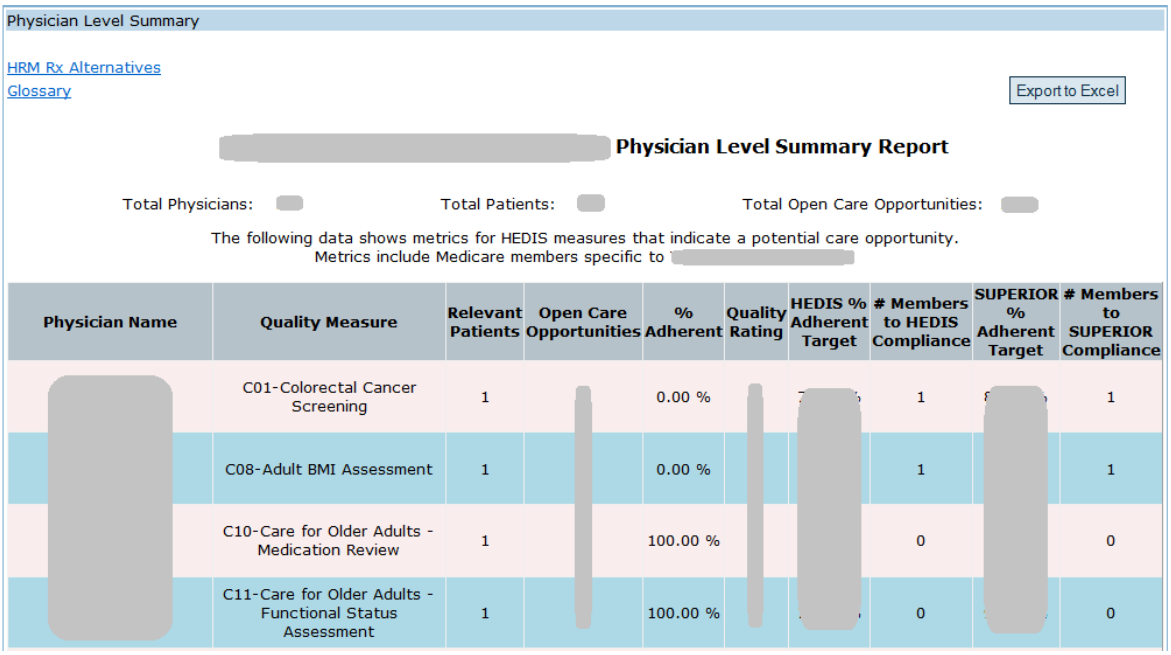
This report displays the following key fields.

Physicians: Displays the total number of physicians within the provider group assigned (or attributed) as the PCP for a member.

Total Patients: Displays the total number of members with an assigned PCP that is part of the provider group

- **Physician Level Summary Report**

  Summarizes by physician (MPIN) the number of members for each recommended HEDIS and Part D measure. Additionally, the number of members eligible for the screening as well as current and prior reporting period compliance is shown. Quality Outcomes and Clinical Performance represent performance based on HEDIS and/or STAR specifications.


Physician Level Summary

HRM Rx Alternatives
Glossary

Export to Excel

[redacted] Physician Level Summary Report

Total Physicians: [redacted] Total Patients: [redacted] Total Open Care Opportunities: [redacted]

The following data shows metrics for HEDIS measures that indicate a potential care opportunity.
Metrics include Medicare members specific to [redacted]

Physician Name	Quality Measure	Relevant Patients	Open Care Opportunities	% Adherent	Quality Rating	HEDIS % Adherent Target	# Members to HEDIS Compliance	SUPERIOR % Adherent Target	# Members to SUPERIOR Compliance
[redacted]	C01-Colorectal Cancer Screening	1	[redacted]	0.00 %	[redacted]	[redacted]	1	[redacted]	1
	C08-Adult BMI Assessment	1		0.00 %			1		1
	C10-Care for Older Adults - Medication Review	1		100.00 %			0		0
	C11-Care for Older Adults - Functional Status Assessment	1		100.00 %			0		0

This report displays following key fields:

Relevant Patients: All members assigned or attributed to a physician in the group that have at least one open or closed care opportunity for any of the HEDIS and Part D metrics identified on the Member Compliance Report.

Quality Rating: A calculated field showing current adherence for that metric for that group based on the 2012 CMS STAR Rating thresholds.

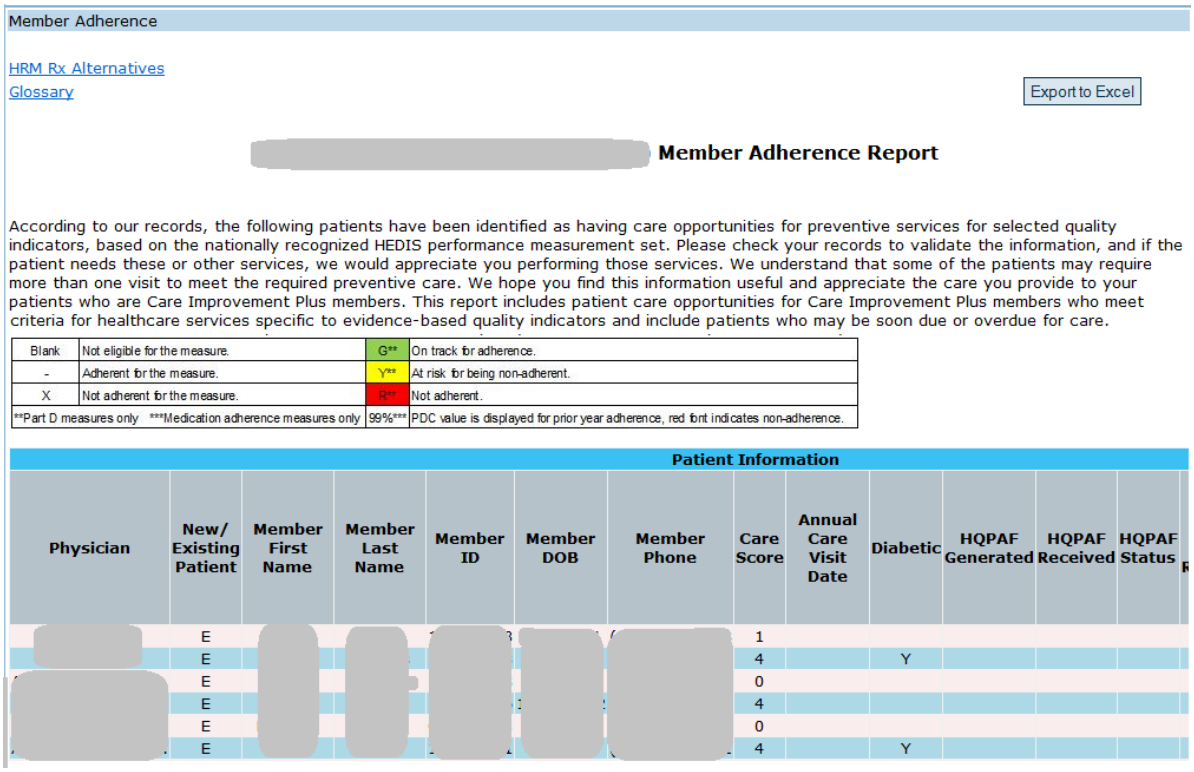
Open Care Opportunities: Displays the total of gaps in care for the HEDIS measures and Pharmacy current year gaps as defined by the alert levels on the Member Adherence Report where: R= Gap; Y=Gap; and G= No Gap.

Physician Level Summary Report also displays the detailed information for Physician Name, Quality Measures, Relevant Patients, Open Care Opportunities, Non Adherent

and Adherent percentage, Prior Adherent Reporting Period percentage, Adherent Trend, Quality Rating and Adherence Target percentage.

- **Member Adherence Report**

  Summarizes care opportunity data by physician (MPIN) each HEDIS and Part D measure.



Member Adherence

HRM Rx Alternatives
Glossary

Export to Excel

[redacted] **Member Adherence Report**

According to our records, the following patients have been identified as having care opportunities for preventive services for selected quality indicators, based on the nationally recognized HEDIS performance measurement set. Please check your records to validate the information, and if the patient needs these or other services, we would appreciate you performing those services. We understand that some of the patients may require more than one visit to meet the required preventive care. We hope you find this information useful and appreciate the care you provide to your patients who are Care Improvement Plus members. This report includes patient care opportunities for Care Improvement Plus members who meet criteria for healthcare services specific to evidence-based quality indicators and include patients who may be soon due or overdue for care.

Blank	Not eligible for the measure.	G**	On track for adherence.
-	Adherent for the measure.	Y**	At risk for being non-adherent.
X	Not adherent for the measure.	R**	Not adherent.
**Part D measures only ***Medication adherence measures only		99%***	PDC value is displayed for prior year adherence, red font indicates non-adherence.

Patient Information													
Physician	New/ Existing Patient	Member First Name	Member Last Name	Member ID	Member DOB	Member Phone	Care Score	Annual Care Visit Date	Diabetic	HQPAF Generated	HQPAF Received	HQPAF Status	R
[redacted]	E	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1						
	E						4		Y				
	E						0						
	E						4						
	E						0						
	E						4		Y				

This report has following key fields:

Member ID: The number found on the member's identification card. For some dual eligible members, the field may be blank.

Care Score is a Care Improvement Plus calculation which uses a combination of a measure's adherence status and the weight of the HEDIS and/or pharmacy measure for each relevant member. Its purpose is to quantify the care needed for each member based on CMS guidelines.

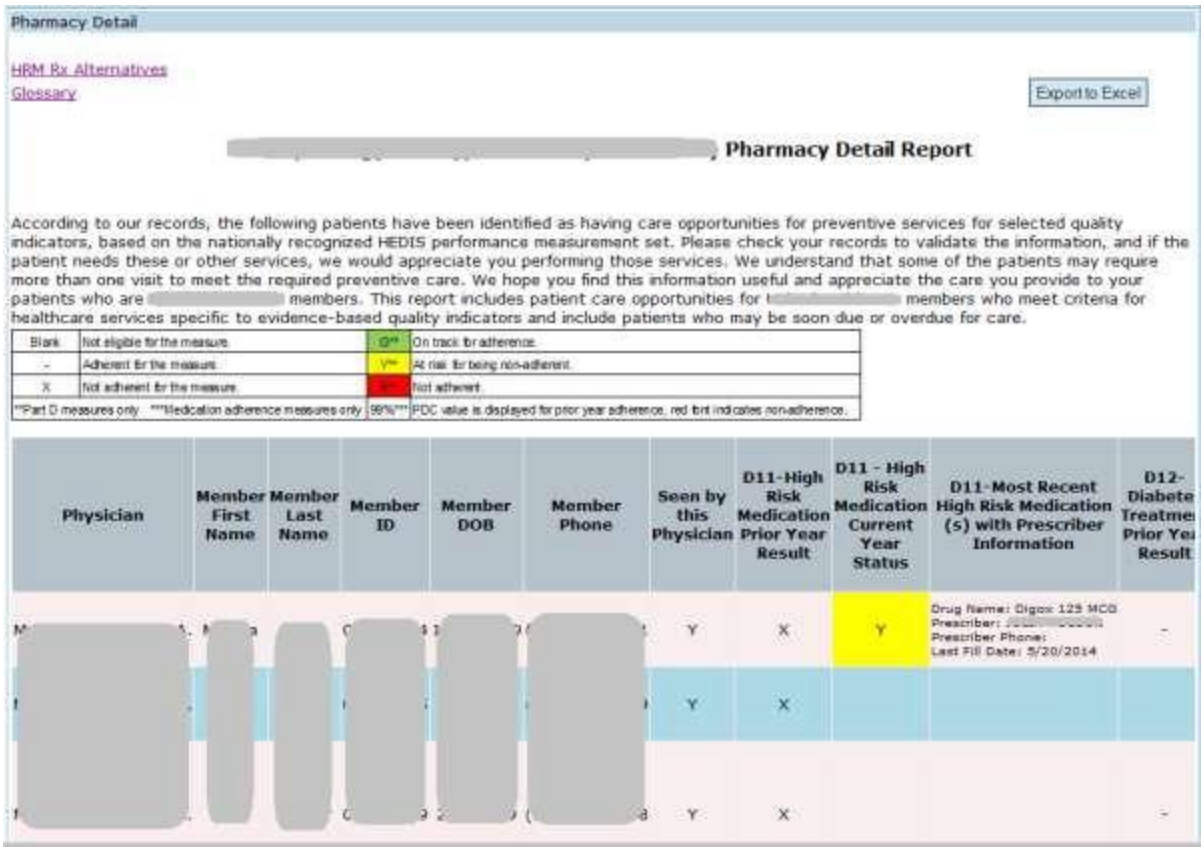
Last Wellness Exam: Displays date that this member had a wellness exam although not necessarily with the physician to which the member is currently assigned. Last Wellness Exam will be determined by the most recent claim with the following procedure codes:

- ICD-9-CM Diagnosis Codes: V70.0, V70.8, V70.9
- HCPCS codes: G0402, G0438, and G0439
- CPT Codes: 99385-99387 and 99395-99397

This report also displays the detailed information about Physician, Patient type (New/Existing), Member details, Care score, Last wellness Exam and different quality measures for that member.

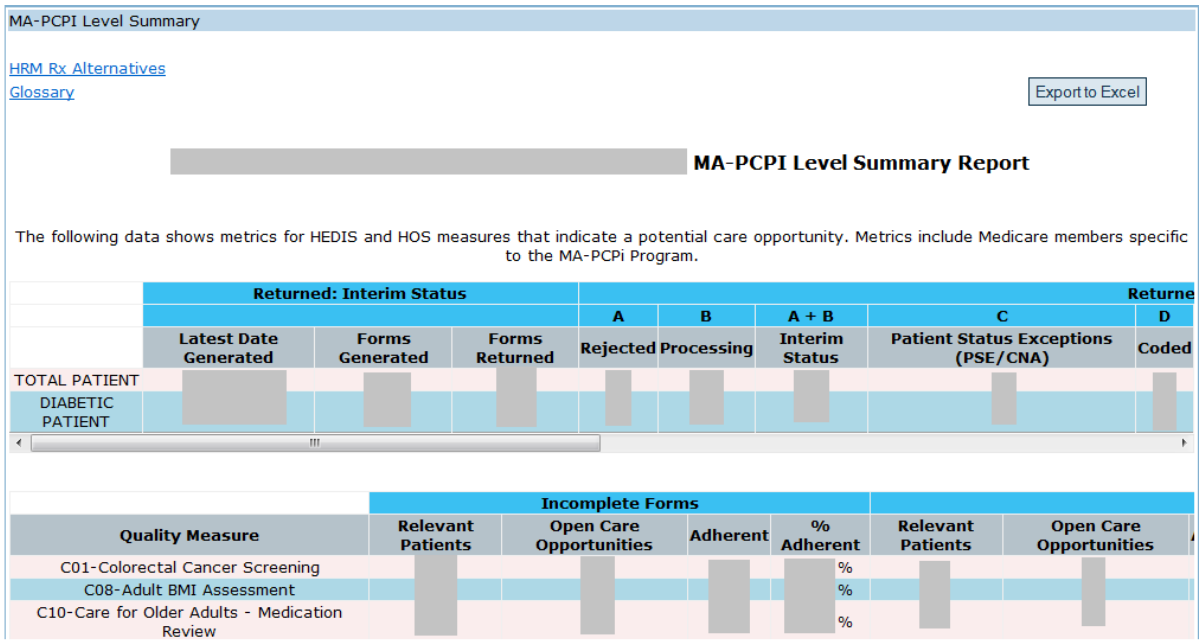
- **Pharmacy Detail Report**

  Provides objective member specific information including drug name(s), dates prescriptions were last filled, Prescriber and Pharmacy information. This report may be used to proactively close gaps.


Pharmacy Detail
HRM Rx Alternatives
Glossary
Export to Excel
Pharmacy Detail Report
According to our records, the following patients have been identified as having care opportunities for preventive services for selected quality indicators, based on the nationally recognized HEDIS performance measurement set. Please check your records to validate the information, and if the patient needs these or other services, we would appreciate you performing those services. We understand that some of the patients may require more than one visit to meet the required preventive care. We hope you find this information useful and appreciate the care you provide to your patients who are members. This report includes patient care opportunities for members who meet criteria for healthcare services specific to evidence-based quality indicators and include patients who may be soon due or overdue for care.
Blank Not eligible for the measure
- Adherent for the measure
X Not adherent for the measure
**Part D measures only ***Medication adherence measures only
Physician
Member First Name
Member Last Name
Member ID
Member DOB
Member Phone
Seen by this Physician
D11-High Risk Medication Prior Year Result
D11 - High Risk Medication Current Year Status
D11-Most Recent High Risk Medication (s) with Prescriber Information
D12-Diabete Treatme Prior Ye Result
Drug Name: Digox 125 MCG
Prescriber:
Prescriber Phone:
Last Fill Date: 5/20/2014

MA-PCPi Level Summary Report

This Report displays a summary for each individual MA-PCPi group of the status of all HQPAFs distributed and returned for all MA- PCPi participating groups as well as a Quality Measure Summary for incomplete forms and completed forms. Incomplete forms include all members for whom a HQPAF was generated minus the forms that were returned with patient status exceptions and the completed forms that went through the coding/recording process. Completed forms are those that went through the coding/recording process. Additionally, the number of members required to reach HEDIS and SUPERIOR adherence rates and the number of forms required to reach the 60% threshold are shown.


MA-PCPI Level Summary

HRM Rx Alternatives
Glossary

Export to Excel

MA-PCPI Level Summary Report

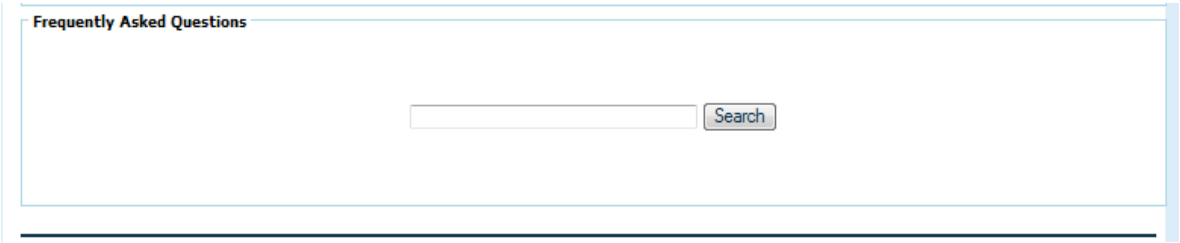
The following data shows metrics for HEDIS and HOS measures that indicate a potential care opportunity. Metrics include Medicare members specific to the MA-PCPi Program.

	Returned: Interim Status								Returne
				A	B	A + B	C		D
	Latest Date Generated	Forms Generated	Forms Returned	Rejected	Processing	Interim Status	Patient Status Exceptions (PSE/CNA)		Coded
TOTAL PATIENT									
DIABETIC PATIENT									

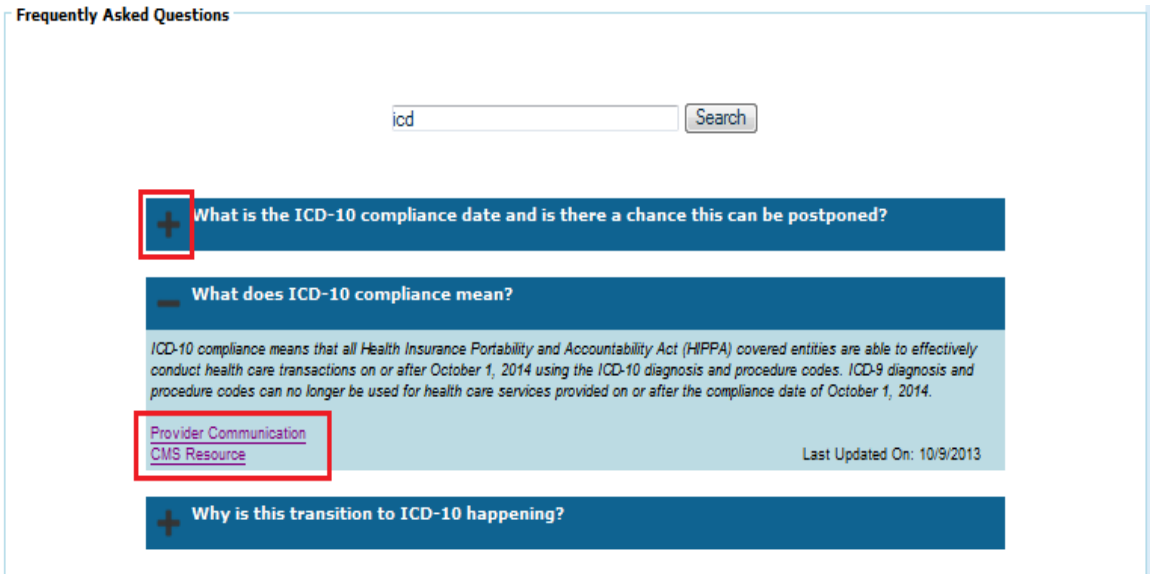
	Incomplete Forms						
Quality Measure	Relevant Patients	Open Care Opportunities	Adherent	% Adherent	Relevant Patients	Open Care Opportunities	
C01-Colorectal Cancer Screening				%			
C08-Adult BMI Assessment				%			
C10-Care for Older Adults - Medication Review				%			

3.9 FAQs

This section provides information pertaining to any questions the user may have. This is a key-word-driven search engine.



Type the question or keyword (Minimum 3 characters) in the search text box field and all the information related to search field will be shown under the search option. The question can be expanded by clicking on '+' icon to find the related answer. It also contains related links such as '*Provider Communication'* and '*CMS Resource'*. Related information can be found by clicking on any of this links. The user can also find the last updated information on bottom right corner of the answer.


Frequently Asked Questions
icd
Search
What is the ICD-10 compliance date and is there a chance this can be postponed?
What does ICD-10 compliance mean?
ICD-10 compliance means that all Health Insurance Portability and Accountability Act (HIPPA) covered entities are able to effectively conduct health care transactions on or after October 1, 2014 using the ICD-10 diagnosis and procedure codes. ICD-9 diagnosis and procedure codes can no longer be used for health care services provided on or after the compliance date of October 1, 2014.
Provider Communication
CMS Resource
Last Updated On: 10/9/2013
Why is this transition to ICD-10 happening?

3.10 Contact Us

This page provides Health Plan contact information related to claims submission, Appeals, Inpatient Hospital Admission Authorization, Eligibility Inquiry and Web Portal Support such as e-mail, fax, TTY and phone numbers.

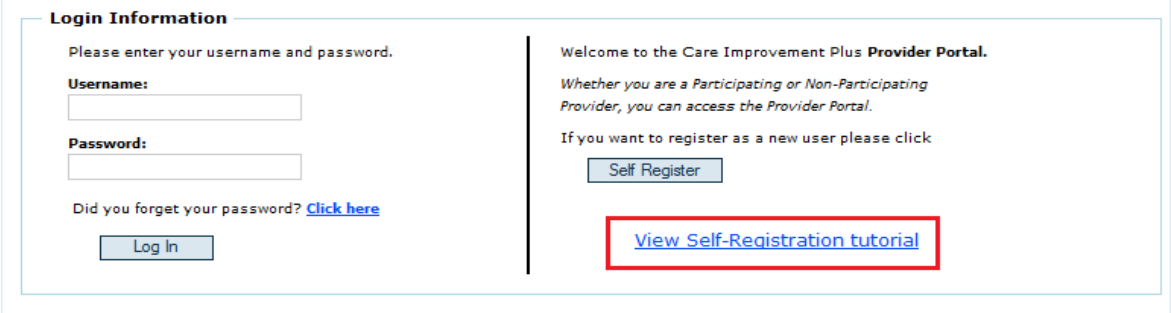
4 Tutorials

This section provides the tutorial videos about the different functions of the portal and helps user to understand how to navigate the system and use its specific features. The tutorials section can be access through the *Tutorials* tab on upper right corner of the portal.

The user can find video tutorials on the following topics:

- How to self-register
- How to verify member eligibility
- How to search claims and viewing claim details
- How to dispute a claim
- Medical Records Upload
- How to request a remit if one is not immediately available
- How to view forms and guides
- How to view provider news
- How to verify post payment audit
- Appeal and Reconsideration Upload

The user can also access the Self-Registration *Tutorial* through the Log In page.


Login Information
Please enter your username and password.
Username:
Password:
Did you forget your password? Click here
Log In
Welcome to the Care Improvement Plus Provider Portal.
Whether you are a Participating or Non-Participating Provider, you can access the Provider Portal.
If you want to register as a new user please click
Self Register
View Self-Registration tutorial

To access the tutorial videos, click on *Tutorial* link and the page with tutorial videos will open up. Click on the video icon or the video topic to play the video. The video will be played in a new window after clicking on the icon.

User Tutorials

- How to self register

- How to request a remit if one is not immediately available

- How to verify member eligibility

- How to view forms and guides

- How to search claims and viewing claim details

- How to view provider news

- How to dispute a claim

- How to verify post payment audit

- Medical Records Upload

- Appeal and Reconsideration Upload

5 Disclaimer

- Care Improvement Plus has made every effort to ensure that this User's Manual is accurate and up to date. Care Improvement Plus disclaims liability for any inaccuracies or omissions that may have occurred and makes no commitment to keep the information update or current.

- Information in this manual is subject to change without any prior notice. No part of this manual shall be assumes any liability to the users.

- All rights are reserved to Care Improvement Plus.

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